ADOLESCENT ATTITUDES TOWARDS THE PROVISION AND USE OF CONTRACEPTIVES IN KAMUKUNJI CONSTITUENCY, NAIROBI CITY COUNTY

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DECLARATION

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

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

Signature ……..…… **Date ……**

Prof. Simiyu Wandibba

DEDICATION

I dedicate this work to my late mother Margaret Wambui Kung'u for believing in me and grant her final resting wishes. I am forever indebted to her courage, determination, resilience, and wisdom.

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ABSTRACT

The study assessed adolescents' attitudes towards the provision and use of contraceptives in Kamukunji Constituency, Nairobi City County. The study had two objectives namely: 1) to investigate the attitudes of adolescents in the constituency towards the provision and use of contraceptives; 2) to describe factors that determine these attitudes. The study was descriptive in nature and was guided by social norms theory and anchored on the fact that an individual's behaviour is affected by their peers' perceptions. Data was collected through semi-structured interviews, key informants and FGDs. 50 adolescents were sampled, 25 male and 25 females. Quantitative data was analysed using MS-Excel. Qualitative data from the semi-structured interviews, key informant interviews and FGDs were coded and analysed thematically. The findings indicate that the attitudes of adolescents are similar because most of the adolescents sampled were in support of and open to provision and use of contraceptives. In addition, the study found that adolescents are sexually active but have very limited access to contraceptive information and services. It was also evident that adolescents do not have significant people in their lives talking to them about contraceptives. Social networks, including peers and significant people, access to contraceptive products that include related information and services, social and gender norms, were found to affect provision and use of contraceptives by adolescents. The study concludes that, one, adolescents are sexually active and therefore need information on the provision and use of contraceptives to deal with the problems of early pregnancies and the possibility of being infected with STIs. Two, social networks are an important factor in the provision and use of contraceptives by adolescents. The study therefore recommends, one, adolescents should be provided with the necessary information on the provision and use of contraceptives so that they can make informed choices about their reproductive health. Two, the study recommends that adolescents should be mainstreamed in awareness and advocacy platforms that seek to change societal attitude towards provision and use of contraceptives. Finally, the study recommends further studies on the subject in other areas of the City County to see if there are any similarities or differences in the attitudes of adolescents in those areas towards provision and use of contraceptives.

LIST OF ABBREVIATIONS

AIDS: Acquired Immunodeficiency Syndrome

GPS: Global Positioning System

HIV: Human Immunodeficiency Virus

IUDS: Intrauterine Devices

KDHS : Kenya Demographic and Health Survey

KHRC: Kenya Human Rights Commission

KNBS : Kenya National Bureau of Statistics

STIs: Sexually Transmitted Infections

UN: United Nations

UNFPA: United Nations Population Fund

USAID: United States Agency for International Development

WHO: World Health Organization

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

Contraceptives are methods, devices or drugs used to prevent the occurrence of a pregnancy by stopping the egg production and stopping the fertilized egg from attaching to the lining of the womb (NHS, 2010). Access to contraceptive services is an essential human right for all individuals regardless of age or gender. Despite this, adolescents are faced with social, economic and health challenges (Mumah et al., 2014). Due to existing traditional and cultural practices, some communities believe that adolescents below the age of eighteen years should not use contraceptives.

Despite the fact that the legal age of access to contraceptives in Kenya is eighteen years, it should not necessarily mean that adolescents below the age of eighteen should not access the same services. Worth mentioning is that negotiations between organizations globally have embraced and recommended that adolescents between 15- 24 years have the right to sexual reproductive education and access to sexual and reproductive health services (Center for Reproductive Rights and UNFPA, 2010). This implies that adolescents in that age group should be allowed to make their own choices regarding the use of contraceptives.

According to Mumah *et al*. (2014), the high level of unintended pregnancy in Kenya is due to low contraceptive use among women and girls. Indeed, among sexually active 16% of 15-19 year-olds have low contraceptive prevalence rate. In addition, the research revealed that adolescents in the slums engage in sexual activity earlier and are likely to

report transactional sex, unprotected sex, and have multiple sexual partners compared to their counterparts in other areas. This exposes them to unwanted and unplanned pregnancies. An earlier study by Kinaro (2012) had found that at least 41% of the girls aged 15-22 years living in slums had experienced accidental pregnancy. This study further found that improving contraception use in all adolescents, both male and female, has the potential benefit of not only female empowerment but also educational and socio-economic opportunities. According to Munene (2015) the use of contraceptives in slums will help improve the community since urban slums have at least 30% adolescents of the total population.

1.2 Problem Statement

Studies indicate that low use of contraceptives by adolescents exposes them to adverse consequences such as early pregnancies, sexually infected diseases such as HIV, and school dropouts. United Nations Children's Fund (2013), in 2012, found adolescents' aged 15-19 years accounted for at least 13% of new HIV infections all over the world. KNBS and ICF Macro (2014) found that 50.1% of sexually active unmarried women aged 15-19 were either on traditional or modern contraception, with teenage pregnancy being at 18%. The question to ask then is, what factors influenced these women to use those methods of contraception, and why contraceptives use by adolescents so low?

Reproductive Health and Rights Alliance and Kenya Human Rights Commission (2009) found the root cause of abortions, especially in slums, is early pregnancies which are due to the nominal use of contraceptive among adolescents. Kabiru and Orpinas (2009) state that most adolescents living in the informal settlements tend to engage become sexually active at a very young age compared to adolescents in other areas. Further, the earlier

they engage in sexual activities, the more they tend to spill into having multiple partners and even transactional sex that sometimes leads to unprotected sex.

Male adolescents have been found to have multiple sexual partners as a way of life while their female counterparts have been linked to resulting to sex as a means of getting some extra financial help from men (Kenya Human Rights Commission and Reproductive Health and Rights Alliance, 2010). In addition, responsibility on the use of contraceptives has been left to adolescent girls since they have more adverse consequences compared to the boys. This study, therefore, aimed at examining adolescents' attitudes towards provision and use of contraceptives in Kamukunji Constituency, Nairobi City County by answering the following questions:

1. What are the attitudes of adolescents in Kamukunji Constituency towards provision and use of contraceptives?
2. What factors determine these attitudes towards provision and use of contraceptives?

1.3 Objectives of the Study

1.3.1 General Objective

To explore adolescents' attitudes towards provision and use of contraceptives as well as the factors that influence those attitudes in Kamukunji Constituency, Nairobi City County.

1.3.2 Specific Objectives

1. To investigate adolescents' attitudes in Kamukunji Constituency towards the provision and use of contraceptives.

2. To describe factors that determine these attitudes of adolescents towards the use of contraceptives.

1.4 Assumptions of the Study

1. The provision and use of contraceptives by adolescents in Kamkunji Constituency is influenced by certain attitudes.
2. The provision and use of contraceptives by adolescent in this Constituency is determined by certain factors.

1.5 Justification of the Study

Adolescents are a critical group of people that require significant attention especially now that advancement in technology has exposed this group to higher risks than in previous centuries. Social media and some television programmes expose this group to a lot of content that is not recommendable for their age. This builds up curiosity among them, posing greater risks based on the fact that some of them want to try out what they see. Some of these risks pose a significant danger to their health such as contracting STIs and botched abortions (WHO, 2014). Based on a study by Zulu *et al.* (2002), most of these risks affect younger girls compared to their male counterparts. This is because risks such as STIs and abortions affect the female health system to a greater extent, which in some cases may lead to them being sterile.

Understanding the attitudes of adolescents towards the provision and use of contraceptives will be of great significance since the study has shown how best to combat the consequences that are brought about by the minimal use of contraceptives by adolescents in informal settlements. Thus, the study findings should benefit organizations

working towards reducing teenage pregnancies and unsafe abortions. Parents and health facility officers have the opportunity to understand the adolescents better and develop ways to educate them contraceptives use. Adolescents too had a chance to express their opinions in a matter that directly impacts on their health and wellbeing. Further, the study findings have added to existing knowledge on adolescent reproductive health rights discussion and has availed baseline data for further studies in the county and beyond..

1.6 Scope and Limitations of the Study

The study was conducted Kanuku and Kinyago informal settlements, California Ward, Kamukunji Constituency. It focused on adolescents' attitudes towards the provision and use of contraceptives as well as the factors that determine these attitudes. The study was descriptive and was guided by the social norms theory.

The study limited itself to Kanuku and Kinyago informal settlements in Kamukunji and, therefore, other informal settlements in the Constituency were not included in the sample. This implies that the findings cannot be generalized because it was just based on a specific area of Nairobi City County and did not consider other constituencies and counties. In addition, the study sample consisted of a mere 50 adolescents. Hence, these findings might not be a representation of all adolescents living in Kanuku and Kinyango informal settlements. However, the findings can form the basis for other studies in the same area or in different environmental settings.

Furthermore, some of the respondents were not forthright with their views, opinions, and participation. However, the researcher was able to converse with them and assure them of the confidentiality of the research. She also allowed them to read and write on their own,

coming in only to assist them to interpret items in the questionnaire that they did not understand.

1.7 Definition of Terms

Access to contraceptives: The ease with which an adolescent can get contraceptive services.

Adolescent: An adolescent in this study was an individual aged15-19 years.

Attitude: In this study, this refers to how an adolescent thinks or feels about provision and use of contraceptives.

Contraceptives: Any device/drug used to prevent the occurrence of a pregnancy: either through separating the egg and sperm and stopping the production of the egg, or else stopping the fertilized egg from attaching to the lining of the womb (NHS, 2010).

Gender norms: Social norms that resonate with gender differences. These are informal rules, beliefs and social expectations that distinguish specific expected behaviour based on gender.

Informal settlement: A settlement in an urban area that is characterized by poor living conditions.

Perception: How someone views a certain point, in this case how an adolescent views the use of contraceptives.

Legal age: The age at which an individual becomes adulthood

	legally. It is the age at which children assume legal responsibility over themselves, their actions, and decisions.
Sex:	The act of the male reproductive system (penis), entering the female reproductive system (vagina).
Sexually active:	In this study, this refers to an adolescent who had engaged in sexual activities within the previous six months before the research.
Sexual activity:	The act of individuals engaging in sex, with or without consent.
Social norm:	Acceptable behaviour that a given individual is expected to conform to in a particular social group or community.
Use of contraceptives:	The act of utilizing a particular contraceptive method to serve one's purpose.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents literature relevant to the research problem that was reviewed. The review encompassed the following headings: contraceptives, perceptions of adolescents on use of contraceptives, and factors affecting the provision and use of contraceptive services. The chapter also discusses theory that was used to guide the study.

2.2 Contraceptives

As defined by the National Health Service (2010), contraceptives refer to medication and devices used to prevent the occurrence of pregnancy. Besides, some contraceptives such as condoms are not only used for the prevention of pregnancy but also in the prevention of infections that are transmitted sexually. We have different types of contraceptives on the market. One is the barrier method which, as the name suggests, means blocking or creating a barrier to avoid the sperm from reaching the egg. Some of the contraceptives under this are both male and female condoms.

A point to note is that condom use is the most sought after method by adolescents since it has numerous advantages that work in its favour. One of its key benefits is that condoms are readily available in shops, kiosks, and chemists. Thus, adolescents do not have to necessarily walk to health facilities to get them. Other benefits include, but are not limited to, being effective against sexually transmitted diseases, are convenient, can work with other contraceptives and have no side effects (Planned Parenthood, 2010).

Known as one of the most effective methods of contraception, implantable devices are another way of avoiding pregnancy whereby the device is inserted into the body and left in place for the specified. In the category, are two types of devices, the implantable rod and the intrauterine device, mostly known as the coil. The rod is usually place on the upper part of the arm beneath the skin, which works by releasing a hormone called progestin that causes the uterus lining to experience some few changes allowing the cervical mucus to prevent the sperm meeting with the egg. Most popular brands in the market currently are Jadelle and Implanon (Motherhood 101, 2016).

The intrauterine device is small device that shaped as T, and it works almost similar to the Implanon by producing progestin inhibit ovaries intact from egg release. The intrauterine device inhibits a fertilized egg from implanting onto the uterus (Motherhood 101, 2016). Even though they have been proven to be effective, most adolescents do not prefer the use of these two devices since they can be easily detected, especially the rod.

The hormonal contraceptive method interferes with the fertilization, ovulation or implantation of the fertilized egg thereby preventing pregnancy. Pills and the injection (also known as the depo) fall into this category. According to Ernst (2018) a writer with Health Line Organization, hormonal methods have been a lifesaver for women who want to prevent pregnancy. Most youths, especially adolescents, prefer this method since it is easier to work with. Unlike the use of devices such as IUD, the use of injection is entirely confidential; you are only required to visit the health facility once in three months to get the shot. Some key benefits of this method are that it helps in the regulation of menstrual cycles, there is less period pain during menstruation and it reduces the risk of uterine cancer.

Last, but not least, are the permanent contraceptives that are not advisable for adolescents. These include vasectomy and tubal ligation. Both methods ensure that individuals are not able to sire children or conceive permanently.

2.3 Perceptions of Adolescents on the Use of Contraceptives

WHO (2013) allows adolescents to use contraception methods of chopice. In a study that sought to understand the knowledge of adolescents on the use of contraceptives, found adolescents were aware of different methods of contraception available in the market (Miano and Masherenin, 2014). Despite the fact that there is inadequate literature on the viewpoints, attitudes and environmental factors influencing adolescents on the use of contraceptives, existing perceptions on contraceptive use are influenced and shaped by family members, students, teachers and the media who give information (Miano and Masherenin, 2014). All these individuals fall under the category of social reference groups that influence the society greatly.

According to Williamson *et al*. (2009) a very small number of adolescents who are sexually active, more so, in third world countries, are using contraceptives, even though this may vary with each country. The researchers also explain that the most commonly used contraceptive is the condom and the emergency pill. This is because condoms in some countries, such as Kenya, are readily available and are usually dispensed freely in schools, colleges and even public amenities (WHO, 2013). In the case of emergency contraceptives, most adolescents tend to engage in sexual intercourse and use these contraceptives to prevent pregnancy.

Factors contributing to low contraceptives use by adolescents are: limited sex education; limited access to contraceptive services; lack of knowledge and information; and negative social norms and misconceptions.

Adolescents have poor sexual and reproductive health (SRH) due to social, cultural, economic, and structural barriers that function to discourage their access to appropriate contraceptive services. The general perception of teenage contraception, especially if the teenager is not married, discourages adolescents from seeking contraceptive services as well as using the contraceptive options that are available. This is attributed to the fact that adolescents are fearful of how they will be perceived by society when they are known to be using contraceptives. Further, adolescents may be skeptical about the kind of reception they will receive once they state that they are seeking contraceptive services yet they are unmarried. Some contraceptive providers also decline to offer contraceptive services to unmarried adolescents as they believe that this would encourage premarital sexual activity. However, research has shown that denial of contraceptive services to adolescents does not influence sexual behaviour (Kirby, 2007).

2.4 Factors Affecting the Provision and Use of Contraceptive Services

2.4.1 Accessibility

According to UNFPA (2010), the lack of access to contraceptives has brought about an epidemic whereby at least one among four women is not using any contraceptive method to prevent pregnancy. Thus, lack of access to contraceptive services means that most adolescents are exposed to from sexually transmitted diseases and at the same time cannot control their fertility and reproduction choices (UNFPA, 2010).

A study by Munene (2015) shows that there are contraceptives readily available in informal settlements, with non-governmental organizations have taking up the role of opening up various health centres in different proximities, which are cost-friendly to provide these services to low earning individuals. These organizations provide youth-friendly services that enable adolescents to walk into health facilities and get counselled on which contraceptives work for them best. Contraceptives such as condoms are readily available in kiosks and chemists, and some are even dispensed in schools and other public amenities.

Based on the findings from a study conducted by Munene (2015), the access to contraceptives is not the main issue on why adolescents may not be using contraceptives but rather the key question is what the hindrances in using the contraceptives are. The social norms theory comes into play since societal norms have so far created a barrier to adolescents' use of contraceptives.

Societal norms such as culture, beliefs, and attitudes tend to shape the perceptions of adolescents. When the various people who are critical determinants of social patterns such as parents, chiefs, administrators and religious leaders create a negative attitude towards the use of contraceptives by adolescents below the age of 18 years, then adolescents are not likely to walk into health facilities and inquire more about contraceptives. Instead, they would prefer engaging in sexual activities and dealing with the outcomes later on. Considering adolescents are young people who are still developing mentally, the act of being judged contradicts the act of being a 'cool' teenager in this generation. This means that they fear being judged or regarded as sexually active and so

shy away from inquiring into sexual education. They would rather be known as the cool adolescents who still abide by the societal norms of the community (Munene, 2015).

2.4.2 Peer Pressure

There is extensive research done to determine the significance influence of social networks amongst adolescents' risky health behaviours and outcomes. Despite this, the adolescent contraception use and social networks' role is unclear. Evidence available suggests that behavioural choices by adolescents are partly determined by how acceptable their peers believe the behaviour to be (Evans *et al*., 1995). For Instance, decision on the amount of contraceptive an individual uses is based on contraceptives use of their friends and family member who also serve as the primary source of contraceptive knowledge (Berenson *et al*., 2005). To achieve impactful interventions there is need to understand the influence of social networks and how they work on adolescent contraceptive us and have concrete policies.

This is possible by understanding social processes influencing contraceptive behaviour that can be turned into responsive policies. Peer effects are arguably difficult to estimate, and causal interpretations must be made cautiously as most individuals choose whom to associate with. This implies that, figures that do not necessarily denote peer selection and therefore, cannot be used to identify with accuracy an individual's behavioural choices variation with the behaviour of the reference group. Separating peer influence from unobserved factors associated with peer selection is vital in order to predict accurately successful policies aimed that address risky behaviour among adolescents. In cases where individuals in a peer group have other common underlying characteristics that determine

their behaviour that surpass peer influence, the policies that are founded on peer influence have no effect (Munene, 2015).

In most informal settlements, peers tend to associate themselves with a particular group which has a specific social status. This social status is associated with a few characteristics and perceptions that define the group (Kinaro, 2012). This could be through the activities the group has in common or even their viewpoint on life. An example is a group of girls who market their bodies for financial favours. Now, for an adolescent to join such a status, one will be subjected to doing a few things as a ritual, which may involve certain sexual activities. In such groups, girls are advised to use specific contraceptive methods. In conclusion, peer pressure contributes significantly to the use of contraceptives among adolescents since adolescents tend to copy their friends' lifestyles and life choices without worrying about the social consequences.

2.4.3 Knowledge on Contraception and Contraceptive Use

The level, the amount and the quality of information available to adolescents on contraception determine contraceptives choice and use. There is lack important information on contraceptive methods by adolescents, with available ne being often incorrect (Mehta & Malhotra, 2000). Lack of access to information regarding contraceptives, predisposes girls to teenage pregnancies (Were, 2007).

Health care providers opposed to adolescent contraception provide limited, false information or no information to adolescents who seek contraceptive services or information to promote adolescent abstinence (Kinaro, 2012). Research indicates that limited access to contraceptive by adolescents does not reduce sexual activity but rather

increases the risk of unwanted and unplanned pregnancy and sexually transmitted diseases (Wind, 2005). Further, general lack of guidance on issues of sex and sexuality by parents has been reinforced by cultural taboos inhibiting such discussions (Were, 2007).

Thus, generally, the moralistic nature and the cultural profile of African societies deny adolescents the opportunity to access the necessary information regarding sex, sexuality, and contraception even though evidence shows that adolescents are sexually active. The myths surrounding reproductive topics have a significant bearing on adolescents' reproductive reproductive-health care seeking bahaviour (Valentine *et al*., 2001).

Contraception information at times is not tailored to suit the needs of adolescents, and may be intentionally denied sometimes (Kinaro, 2012). For the majority of adolescents, teachers are their most significant source of information about safe and responsible sex (Kinaro, 2012). However, some adolescents seek information from health providers who give false information about the side effects of teenage contraceptives to discourage pre-marital sex and adolescent contraception and encourage abstinence.

2.4.4 Social Norms

Jaccard and Dittus (2000) found that parents, religious leaders, administrators and teachers play important role in adolescents' lives. They noted that, most adolescents look up to these people and so their behaviours and attitudes influence their actions. In regard to contraceptive use, most parents and religious leaders adopt the abstinence stance and fear discussing contraceptive use with the adolescents. The reason behind this is that they feel that access to available contraceptives will expose these young minds to the

experimental levels leading to early engagement in sexual intercourse. Religious leaders such as Catholic priests and Muslim clerics discourage the use of contraceptives.

However, contrary to all these beliefs and perceptions, providing adolescents with information regarding the use of contraceptives does not in any way promote sexual activity increase. On the contrary, when adolescents are faced with obstacles, they stand more likelihood of negative sexual activity experience. Both social and behavioural norms, should not be key factors that are considered when choosing the method of contraception, although they should not be ignored since they play a role in society and have negative connotation on contraceptive use among adolescents. The most crucial thing in the use of contraceptives is ensuring that all adolescents receive proper counselling before and even after engaging in sexual activities, so that they may be appropriately guided on the use of contraceptives, what works for them with minimal side effects (Jaccard and Dittus, 2000).

Often times, religious leaders, county administrators, teachers, parents, etc., place certain expectations on adolescents. For example, some communities teach men that being sexually active is an integral part of manhood. Thus, in such communities, young men (adolescents) tend to start engaging in sexual activities at an early age even without realizing the consequences of this act. On the other hand, their female counterparts are usuallytaught to abstain from sexual activities and preserve themselves for marriages.

Miano and Masherenin (2014) bring up the question of, if the girls are trained to preserve themselves, why can't the same apply to boys? The issue of social norms and the use of contraceptives in our society has been denied the needed attention which poses a significant risk to the adolescents we have.

2.4.5 Gender Norms

These are gender specific norms that reflect prescribed gender differences (Marcus and Harper, 2015). These are rules, traditions, and beliefs in communities that distinguish male and female behaviour, that is, social expectations that differentiate a male and a female. In the African context, many norms have been put in place to favour either girls or even boys.

Some of these are:

- It is the responsibility of the female to use contraceptives.
- The more partners a male/boy has, the mightier he is on the path of becoming a man.
- It is wrong for an unmarried lady or girl to use contraceptives.

Like in other social settings, most adolescent girls in informal settlements have been subjected to high social expectations by the community. The burden of sourcing for and use of contraceptives has been left to lie on the shoulders of females. Adolescent boys are not questioned on the issue of having different sexual partners; some people applaud them for this behaviour. This encourages teenage boys to engage in sexual activities when very young without any fear of repercussions.

Adolescent girls, on the other hand, are left to make various decisions involving the use of contraceptives. The fact that social expectations in the community recognize the use of contraceptives only for married women and not girls below the age of 18 creates a big barrier to the latter. Adolescent girls tend to fear accessing contraceptives; they fear being judged by society, leaders and even their parents. The results of this are early pregnancies

that lead to dropping out of school, and increased abortion rates since most would rather get rid of the pregnancy than be criticized or even condemned as the black sheep in the community (African Population and Health Research, 2014).

2.5 Theoretical Framework

2.5.1 Social Norms Theory

This study has been guided by social norms theory. The theory was formulated by Perkins (2003a) and it posits that one's behaviour is affected by perceptions of their peers. This implies that our perceptions of peers and other people's attitudes and behaviours have a great influence on our own attitudes and behaviours. This theory further states that rectifying certain misconceptions in society which are perceived as norms will most likely lead to an increase in positive behaviour and a decline in negative behavior. This can be conceptualized as shown in Figure 2.1.

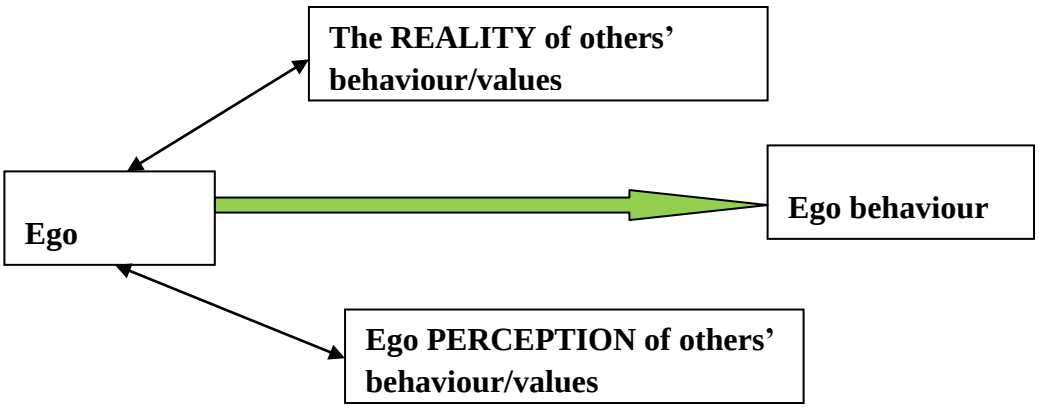


Figure 2.1: Social Norms Theory (Source: www.browardprevention.org)

Currently, social norms theory has gained standing in the field of health research and practices. Similarly, the theory has been used in marketing campaigns aimed at promoting health choices**.** Within the reproductive sphere, there exists a growing recognition that social norms in society greatly influence the attitudes and behaviours of

different age groups including adolescents. Social and behavioural change activities at the community level have shown promising results from the use of social norms transformative methodologies by identifying the individuals who, on a higher percentage, influence target beneficiaries attitudes and behaviours, using communication to transform expectations of behaviour throughout the community (Perkins, 2003c).

The approach has been used to address cases of alcohol and drug abuse successfully, since it focuses on constructive messages about healthy behaviours and attitudes that similar for most individuals within a group, thereby avoiding moralistic messages on how a group should behave. Individuals have friends who are members of groups that in turn form part of a larger community. These groups tend to have similar or different norms that may be of influence to behaviour of individuals in the community. It is therefore imperative to critically look at this influence by social norms (Perkins, 2003b).

For instance, social norms held by staff in organizations offering contraceptive services such as health centres, influence the behaviours of service seekers and, ultimately, facilitate or create obstacles to provision of the services, particularly concerning provision of contraceptive methods to adolescent clients. This can be conceptualized as shown in Figure 2.2 below.

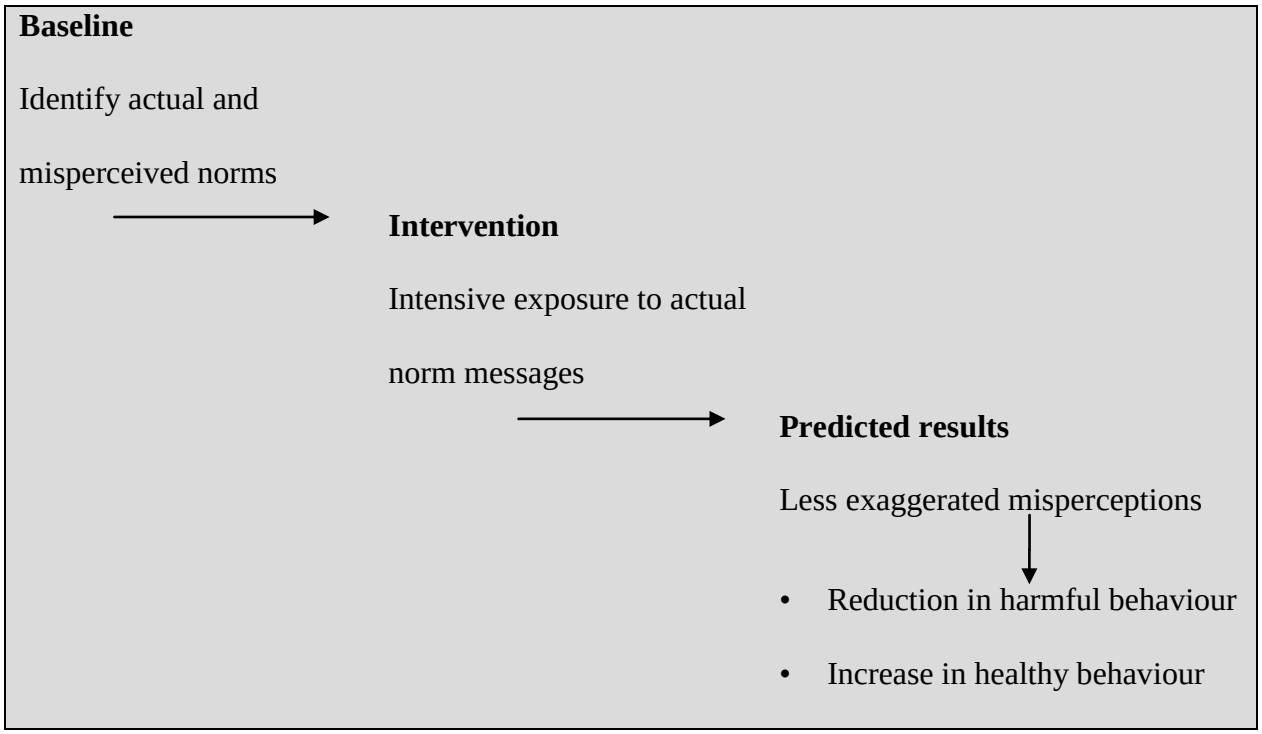


Figure 2.2: Social Norms Model Approach (Source: Perkins, 2003)

2.5.2 Relevance of the Theory to the Study

The theory was useful in explaining how social norms influence adolescents' attitude towards use and provision of contraceptives in informal settlements. Prevailing social norms may influence adolescents' attitudes and behaviour. These social norms may be due to general perception of contraceptives that are informed by peer networks, accessibility, knowledge, or the prevailing perceptions of significant people in adolescents' lives like parents, religious leaders, administrators or teachers. This model is relevant since it responds to the objectives of the study that included attitudes and factors that determine provision and use of contraceptives amongst adolescents in Kamukunji Constituency.

The theory predicts that behaviour is informed by social networks which inform social norms. For the behaviour to happen, social networks have key influence whether actions take place or limit the intended action by an individual. The theory, therefore, shows situations that individuals inaccurately identify with the attitudes and/or behaviours of peers and other community members as being different from their own, a occurrence referred to as pluralistic ignorance (Miller and McFarland, 1991).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the methodology used in the study. It describes the research site, study design and the study population and unit of analysis. The chapter also describes the size of the sample and sampling procedure, data collection methods and data processing and analysis. The chapter entails the ethical considerations that that were adhered to.

3.2 Research Site

3.2.1 General Information

The study was undertaken in Kamukunji Constituency, Nairobi City County of Kenya (Fig. 3.1). Nairobi City County is located at 1°16'S, 36°48'E and covers an area of 695.1km^2. The county is divided into 17 constituencies, namely: Dagoretti North, Dagoretti South, Embakasi East, Embakasi Central, Embakasi North, Embakasi South, Embakasi West, Langata, Kamukunji, Kasarani, Kibra, Ruaraka, Mathare, Makadara, Roysambu, Starehe and Westlands, with each having five wards (Kaggikah, 2017).

Kamukunji Constituency lies in the central and eastern region of Nairobi City County and is bordered by three constituencies, namely, Embakasi West, Kasarani, Mathare, and Starehe. The constituency covers an area of 11.7km^2, and has five wards as follows; Airbase, Eastleigh South, Eastleigh North, California and Pumwani. According to the 2009 population census, the Constituency had 261,855 people, 124,935 females and 136,920 males (KNBS, 2009). Further, the Constituency is divided into five wards, namely, Airbase, Eastleigh South, Eastleigh North, California and Pumwani.

This study was carried out in Kanuku and Kinyago informal settlements of California Ward. The Ward is situated between Biafra Estate, Eastleigh 1st Avenue, Kenya Air Force, and Nairobi River (National Government Constituency Development Fund, 2015). The study site's GPS coordinates are**:** 36.84922E and 1.2876S.

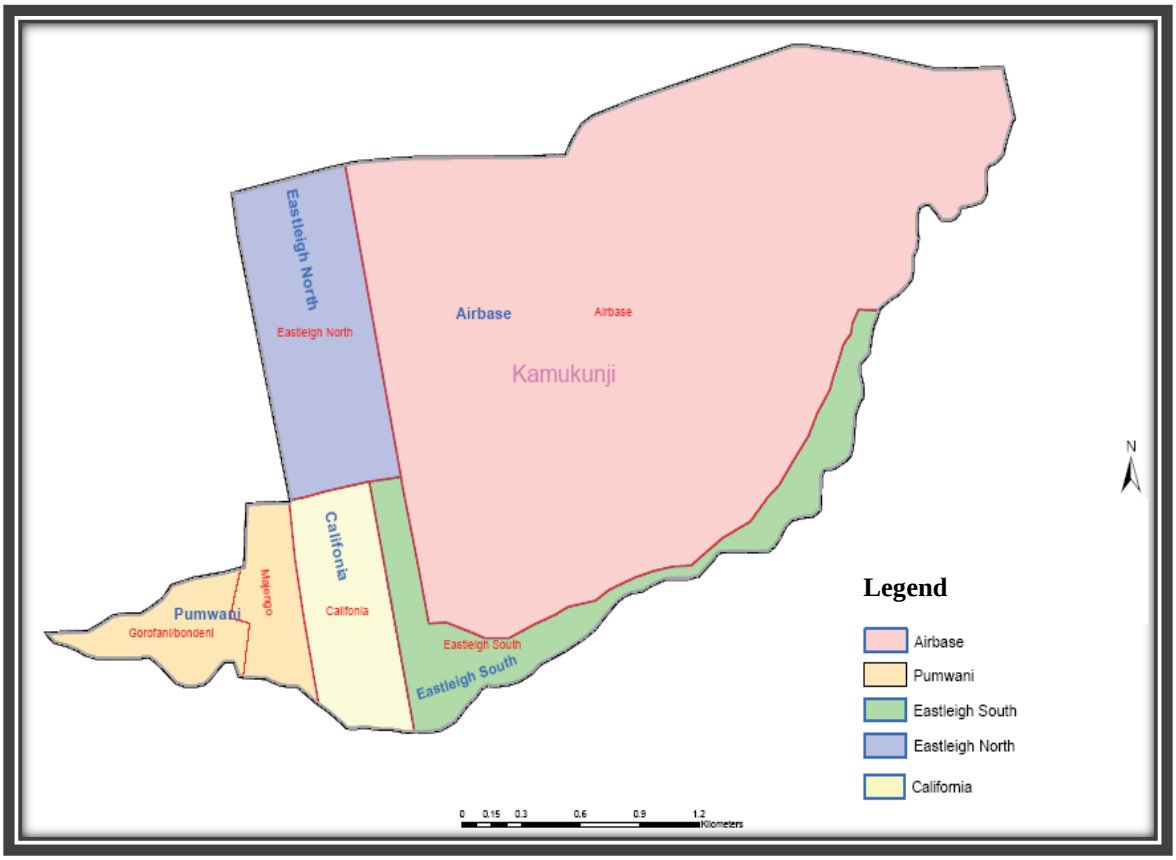


Figure 3.1: Map of Kamukunji Constituency (Source: Information Cradle, 2015)

3.2.2 Socio-Economic Practices

Nairobi is an economic hub of East Africa and is host to people from all walks of life. It is a cosmopolitan society. A large majority of the people in Nairobi City County depend on formal and non-formal employment (KNBS, 2010). A majority of the inhabitants live

in the sprawling informal settlements and earn their living from the informal employment sector such as casual labourers in factories, small businesses and carrier goods (KNBS, 2010).

3.2.3 Reproductive Health

The family planning needs of Kenyan women are yet to be met. For example, a study by KNBS (2010) found that 45% of the women of reproductive age are either not aware of contraceptives or do not use contraceptives. In addition, the National Gender and Equality Commission (2016) found that families in slums expose their children to sex at an early age. This predisposes them to teenage pregnancies and child-sexual activities especially in single dwelling units and where parents engage in commercial sex work. There are intervention like Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Women Project in Kamukunji targets adolescent girls with the aim of reducing HIV/AIDS infection by 40% (USAID, 2019).

3.3 Research Design

The study was descriptive in nature. It employed both qualitative and quantitative methods of research. Quantitative data were obtained using semi-structured interviews while qualitative data were obtained through semi-structured interviews, key informant interviews and focus group discussions. Qualitative data were categorized and analysed according to various themes and patterns that emerged and the findings presented in verbatim quotes. On the other hand, quantitative data were analysed using Ms-Excel and the finding presented in tables of frequencies and percentages.

3.4 Study Population and Unit of Analysis

The population targeted by the study was made of adolescents aged 15-19 years categorized as follows: in school and out of school. The unit of analysis was the individual such adolescent.

3.5 Sample Population and Sampling Procedure

The sample population consisted of 50 adolescents. Convenience sampling method was used to single out respondents, in which the researcher reached out and took the cases that were readily available and continued until the designated number of respondents was realized.

3.6 Data Collection Methods

3.6.1 Semi–Structured Interviews

The researcher held one-on-one interviews with respondents using a semi-structured questionnaire consisting of both closed-ended and open-ended questions (Appendix 2). The open-ended questions were used by the researcher to gather qualitative data and probe further the respondents' responses while the closed-ended questions enabled the researcher to gather quantitative data. This method was used to obtain information on attitudes and factors that affect adolescents' access to and use of contraceptives.

3.6.2 Focus Group Discussions

Communities are rarely homogeneous in their thoughts and, therefore, using FGDs helped the researcher to get consensus on any contentious issues that arose from the semi-structured interviews. The researcher conducted two separate FGDs, one for males and one for females. Each group consisted of 10 participants who did not form part of the

primary sample. The researcher moderated the discussions and ensured they were in line with the research objectives. A focus group discussions guide (Appendix 5) was used to collect the information.

3.6.3 Key Informant Interviews

These were administered through a key informant interview guide (Appendix 4). The questions sought to capture expert knowledge on the provision and use of contraceptives among adolescents. The informants included professionals, development agents, and gate keepers who have first-hand knowledge and understanding of the provision and use of contraceptives by adolescents. These included one woman who was a community leader, one community health worker dealing with adolescent health, one children's officer, two youth leaders' representatives (female and male) to give the perspectives of young people and one technical expert who had been working with adolescents' programmes.

3.6.4 Secondary Sources

The researcher used relevant secondary data sources during the formulation of her proposal through the review of books, journals, research abstracts and the internet as indicated in the literature the review. These were also used throughout the study period.

3.7 Data Processing and Analysis

At the end of the fieldwork, the questionnaires were checked for completeness, and entries reviewed for consistency. Information from semi-structured interviews was checked for completeness and consistency, and then separated into quantitative and qualitative data. Quantitative data were then analysed using MS-Excel and presented using simple descriptive statistical tools like tables and figures. On the other hand,

qualitative data from the semi-structured interviews, key informant interviews and focus group discussions were coded and analysed thematically.

3.8 Ethical Considerations

The researcher ensured that the respondents were not exposed to any harm of physical, emotional or psychological nature. The researcher explained fully the purpose of the research and its potential benefits. Since the research required the respondents to disclose highly sensitive information, confidentiality was maintained at all times and anonymity employed to protect their identity and privacy.

Informed consent was obtained from guardians and/or parents of respondents specifically for those below 18 years. They were made aware of voluntary in the study. The researcher was open and honest and did not exploit the respondents by changing the approved data collection tools or asking questions outside the research area. The researcher also debriefed the respondents after data collection.

CHAPTER FOUR

ADOLESCENT ATTITUDES TOWARDS THE PROVISION AND USE OF CONTRACEPTIVES

4.1 Introduction

This chapter presents the study findings on the basis of the data collected during the research. The findings are presented in tables of frequencies, percentages and chart, and complemented by the interpretation and discussion of the rest of the findings.

4.2 Demographic Information of the Respondents

4.2.1 Age

Age of the respondents was the first characteristic to be evaluated. The findings are presented in Table 4.1 below.

Table 4.1: Respondents Age

Age	Frequency	Percentage
19	13	26
16	10	20
18	10	20
17	9	18
15	8	16
Total	**50**	**100**

Table 4.1 shows that 16% of the respondents were 15 years of age, 10% were aged 16, 18% were 17 years, 20% were 18 years and 26% were19 years of age. The findings indicate that all the respondents were within the target age group of 15-19 years.

4.2.2 Gender

Gender of the respondents is presented in Table 4.2 below.

Table 4.2: Gender of the respondents

Gender	Frequency	Percentage
Male	25	50
Female	25	50
Total	**50**	**100.0**

The study achieved the targeted gender threshold of 50% males and 50% females.

4.2.3 Number of Siblings

To establish the number of siblings that the respondents had, they were asked to share the number of siblings they had. This is shown in Table 4.3 below.

Table 4.3: Number of Siblings

Number	Frequency	Percentage
0	1	2
1	21	42
3	11	22
4	9	18
2	8	16
	50	100

The findings indicate that 42% had one sibling, 22% had three siblings, 18% had four siblings, and 16% had two siblings while 2% had no siblings. The findings also found out that 40% of the respondents were second born, 18% were third born, 10% were an only child, and 10% second born and 4% were first born.

4.2.4 Level of Education

At the time of the study, 10% were in high school, two of whom were in form one while three of them were in form two. Ninety per cent of the respondents were out of school. Of these, 58% of had left school after primary education, 27% had cleared secondary school education and 15% had dropped out while in secondary school. When asked for reasons that made them drop out of school, 27% stated that they had experienced financial constraints and were forced to cut short their education prematurely, 27% had cleared secondary school, 11% of the female respondents had become pregnant, while 22% felt that their parents had absconded their responsibility and did not care for their wellbeing. The out of school adolescents were further asked about their occupation and the results indicate that 73% were not engaged in any activity at the time of the study, 18% were casual labourers and 9% were undertaking skills training.

4.3 Social Networks

The researcher sought to understand the adolescents' social networks. The findings are described below.

4.3.1 People Adolescents Admire

The respondents were asked about who they admired and their relations ship to them. Their responses are shown in Table 4.4 below.

Table 4.4: Persons admired by the respondents

Item	Frequency	Percentage
No one	19	38
Relatives	15	30
Community leaders	9	18
Friends	5	10
Religious leaders	2	4
Total	50	100

Table 4.4 findings indicate 38% of the respondents admired no one, 30% admired relatives, 18% community leaders, 10% friends and 4% admired religious leaders. Those who admired their mothers and brothers constituted 40% and 60% of the respondents, respectively. For the community leaders those who were admired were women leaders, community health volunteers and village elders, represented by 20%, 50% and 30% of the respondents, respectively.

4.3.2 Opinion Shapers

The study wanted to establish the opinions that mattered in adolescent life both in school and general life. The findings are illustrated in Table 4.5 below.

Table 4.5: Individuals whose opinions are important in adolescent school and general life

Individuals	Frequency	Percentage
No one	25	50
Mother	15	30
Brother	5	10
Friend	4	8
Father	1	2
Total	**50**	**100**

The study inquired whose opinions were important to the respondents in terms of their school and general lives. Table 4.5 shows that 50% reported it was no one, 30% said their mother, 10% said their brother, 8% their friend and a minority of 2% said it was their father. This suggests that a half of the respondents never sought any advice on matters related to their schooling as well as their lives in general.

4.3.3 Individuals Adolescents Trust to Discuss Challenges Related to Sexual and Reproductive Health

The adolescent were asked to state the individuals they trusted to discuss with matters concerning sexual reproductive health, including contraceptives. When asked with whom they discussed issues about sexual and reproductive health, including contraceptives, 30% of the respondents kept to themselves, while sometimes they listened to friends, 8% did not discuss with anyone and 62% discussed with friends. This implies that a

significant 38% of the respondents did not discuss the challenges related to sexual and reproductive health with anyone. From the group who discussed with friends, 58% chose to share with boyfriends and girlfriends. The responses are summarized in Table 4.6 below.

Table 4.6: Individuals that adolescents trust on issues of sexual and reproductive health

Individuals	**Frequency**	**Percentage**
Friends	31	62
No one	15	30
I keep it to myself, sometimes I listen to friends	4	8
Total	50	100.0

When asked whose advice or opinions influenced the information the respondents trusted and shared with friends and others, the responses were as displayed in Table 4.7 below. This indicates that 36% of the adolescents shared with boyfriends, 24% with no one, 18% with siblings, 18% with friends, 2% with parents and 2% with church elders. Those who did not consult anyone had reasons for not doing so. Some of those reasons are given below:

"I have been failed by friends, and so I find it is hard to trust them".

"My parents keep on revealing my secrets".

“I do not trust my neighbours; they will say I am sleeping around and start broadcasting me around. In this slum people survive by minding other people’s businesses”.

“My friends will make me the talk of the slum if I share issues about sex and contraceptives. Sometime you have to stay low. Who wants to be gossiped about”?

Table 4.7: Individuals whose advice or opinions influence the information that is trust and share with friends and others

Individuals	Frequency	Percentage
Boy friends	18	36
No one	12	24
Friends	9	18
Siblings	9	18
Parents	1	2
Church elders	1	2
Total	50	100

4.3.3 Influencers

The study also wanted to find out whether opinions of others influenced adolescents’ decisions. The question was, “In the last six months, has concern about what other people would think influenced your decisions about how and where to seek help on contraceptives as an adolescents”? A majority (90%) of the respondents said yes, while 10% said no. The people whose opinions influenced the respondents’ decisions are presented in Table 4.8 below.

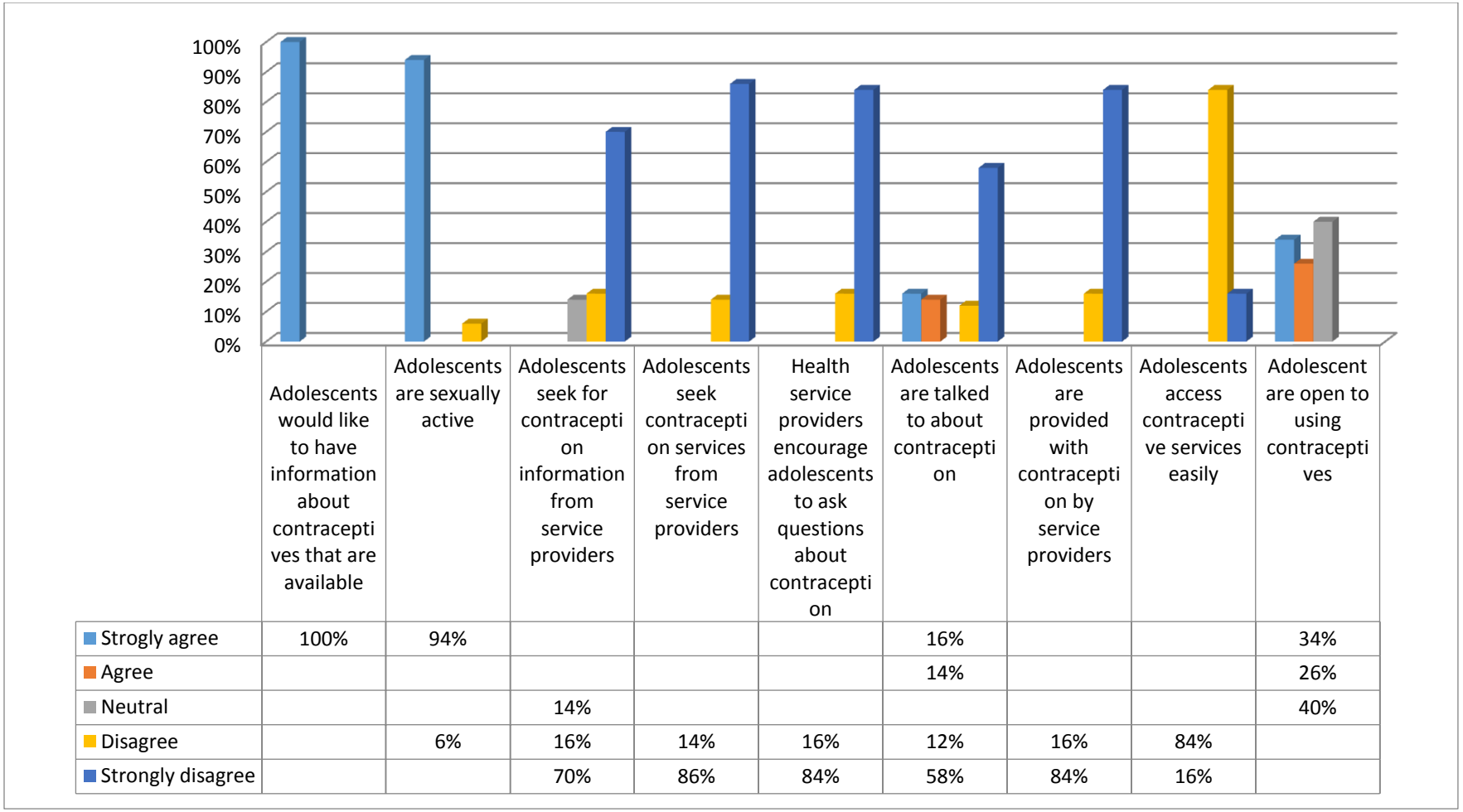
Table 4.8: Persons whose opinions have influenced respondents' decisions

Persons	Frequency	Percentage
Boy/girl friends	18	40
Friends	18	40
Brother	5	11
Community workers	3	7
Parents	1	2
Total	**45**	**100**

The findings show that 90% of the respondents' decisions were influenced by boyfriends/girlfriends, 40% by friends, 11% by brothers, 7% by community workers and 2% by parents. Community workers included neighbours, village elders and community volunteers that the adolescents interacted with.

4.4 Adolescents' Attitudes towards Provision and Use of Contraceptives

The study sought to determine adolescents' attitudes on the provision and use of contraceptives. The findings suggest that 100% of the adolescents sampled agreed that they would like to have information on contraception. Ninety-four per cent of the respondents strongly agreed that adolescents are sexually active while 6% disagreed. When asked whether adolescents seek contraceptive information from service providers, 70% strongly disagreed, 16% disagreed, while 14 were neutral. Further, when asked whether adolescents seek contraceptives from service providers, 86% strongly disagreed while 14% disagreed (see Figure 4.1 below).



	Adolescents would like to have information about contraceptives that are available	Adolescents are sexually active	Adolescents seek for contraception information from service providers	Adolescents seek contraception services from service providers	Health service providers encourage adolescents to ask questions about contraception	Adolescents are talked to about contraception	Adolescents are provided with contraception by service providers	Adolescents access contraceptive services easily	Adolescent are open to using contraceptives
Strogly agree	100%	94%				16%			34%
Agree						14%			26%
Neutral			14%						40%
Disagree		6%	16%	14%	16%	12%	16%	84%	
Strongly disagree			70%	86%	84%	58%	84%	16%	

Figure 4.1: Adolescents' attitudes towards provision and use of contraceptives

In addition, the key informants observed that adolescents face so much judgment because the propelled narrative is that they should be abstaining from sexual activity at this stage of their lives. Most of them are supposed to be in school and so contraceptive use should not be allowed. Despite the fact that most of the key informants were involved with adolescents at the grassroots and at policy level, none was willing to give adolescents contraceptives due to social expectations. They indicated that they would be held responsible if the children were to go ahead and engage in immoral activities. Furthemore, the government has legal age limit of 18. Children below this age are to be protected and not exposed to sexual activities and family planning options.

The FGDs revealed different perspectives on the same topic.

> *Adolescents should be provided with contraceptive and educated on how to use them. To support this, when you walk through this slum, we have so many girls of a young age out of school due to pregnancies. Most of them are sexually active at a tender age due to family issues. Sometimes their parents are drunkards, while others don't care what happens. This applies to both males and females.*

One female respondent pointed out that:

> *Males have multiple children with different girls. Their work is to continuously father children that they cannot take care of. The whole burden falls on the girls. The females should be given the opportunity to access and use contraceptives. Some of these things we have to talk about, especially now that having HIV is like the new trend here.*

The same was echoed by adolescent boys during a FGD, who felt that, unlike girls, they bear few responsibilities when it comes to sexual and reproductive health issues since they do not get pregnant. But despite this, they are concerned that HIV and AIDS are becoming a common occurrence in their age group.

A male respondent pointed out that:

> *Males are open to available options. Whatever the females decide we have no opinion but to follow. After all we do not get pregnant. Our biggest fear is HIV and getting infected with sexually transmitted infections.*

There was a portion of the respondents who felt that contraceptive provision and use should not be allowed.

One respondent gave an example of one girl:

> *Some of the adolescents have been able to access contraception at an early age, especially after primary school education. There is one girl I know, who has been put on contraceptive after class eight because she was sexually active. In the end she dropped out of school for marriage at 16 years. It was like she could do whatever she wanted without worrying. So it is not all that good.*

The study revealed that despite the fact that adolescents would like to be provided with contraceptive services for personal consumption, the community, including service providers, was not receptive due to both social and gender norms and legal constraints. Particularly, if an adolescent girl was to visit the local health facility centres and ask for contraceptive information, the community would jump to the conclusion that she is immoral. This was also echoed by the key informants who noted that the fact that some service providers come from these communities did not make it easier either.

From the FGDs, it was evident that there are challenges that should be addressed if provision of contraceptives to adolescents is to work efficiently and effectively. These are reflected in some of the points raised by respondents bellow:

One female respondent said:

> *Most adolescents are labelled if they try to seek contraceptives. These labels are not good, they erode self-esteem and confidence.*

A male respondent noted:

> *There are inadequate resources to facilitate provision and use of contraceptives by adolescents. There is also societal pressure that blinds people from the reality that 41% of adolescents are sexually active.*

Another female respondent pointed out that:

> *Information is not easily accessible to adolescents. Schools and parents as a unit are still shying away from sexual and reproductive healthcare and the way the world is moving fast. With all these adult movies sites, what are they thinking? They should start talking to us and acting in the right way.*

It was evident from the FDGs that there is need to have the adolescent involved in this discussion**.** Adolescent girls bear the greatest burden of unwanted and unplanned pregnancies. Most adolescents in the study area do not trust their teachers and parents. Similarly, the adolescents are sexually active and there is need to give them the essential information on time as well as facilitate their access to and use of contraceptives.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the study findings as presented in chapter four. It also provides a conclusion and recommendations on policy and further research.

5.2 Discussion

5.2.1 Adolescents' Attitudes towards Provision and Use of Contraceptives

The study found that adolescents have comparatively positive attitudes towards provision and use of contraceptive. A majority of the adolescents would like to have information on and access to contraceptive services. Their attitude is largely shaped by social expectations and there is need to change these perceptions. This study resonates with Miano and Mashereni (2014) who argue that perceptions of contraceptive use are influenced by the information received by the adolescents from social reference groups such as family members, students, teachers and even the media.

As noted by Williamson *et al.* (2009) the study found that very few sexually active adolescents in the study area are using contraceptives. WHO (2013) notes that this may be due to limited sex education, limited access to contraceptives, lack of knowledge and information and negative social norms. The study also found that most of the respondents were of the opinion that adolescents are sexually active and that they needed the right information to avoid teenage pregnancies.

5.2.2 Factors that Determine Adolescents Attitudes towards Provision and Use of Contraceptives

The study found that the factors that determine these attitudes are many and varied. For most adolescents, however, attitude is based on social parameters, some within their control but others beyond them. Peers who include boyfriends, girlfriends and general friends were found to have significant influence over the decisions that adolescents make. Berenson *et al.* (2005) noted an individual's perception of the amount of contraception to use is highly influenced by their social network with friends and family members being the initial knowledge sources on. However, peer influence on decision-making is hard to estimate and needs further research.

The study findings also show that despite the desire to know more about contraceptives, adolescents do not have access to contraceptive information and services at their disposal. In their study, Mehta and Malhotra (2000) found that adolescents often lack essential information on contraceptive methods and where this information is accessible, it is incorrect. In addition, even if information is available, they are not able access to it due to numerous challenges that included the attitude of health care service providers and the prevailing restrictive social and gender norms. This is in agreement with Munene (2015) who posits that lack of access to contraceptives is not the main reason why adolescents may not be using contraceptives, implying that there are multiple reasons for the apathy.

The study findings indicate that social trust and the prevailing social norms weigh upon the decisions that adolescents make. The findings indicate that most of the respondents trusted their friends to discuss issues on contraceptives. The respondents were more concerned about what others would think and say about them. Most adolescents look up

to significant persons in their lives such as parents, teachers and religious leaders when making decisions. Parents and religious leaders held onto the abstinence stance and rarely discuss contraceptives with adolescents. The same case applied to health care providers, just as Jaccard and Dittus (2000) indicate in their study. Society places certain expectations on adolescents for example men are taught at an early age being sexually active is part of being a man (Miano and Mashereni, 2014). Social networks are critical in changing the attitudes of adolescents towards contraceptive provision and use since they inform the prevailing norms.

The study also found that service providers are yet to fully embrace and create adolescent friendly environments. This is despite the fact that they hold a critical role in adolescents' reproductive health rights and should be open to talking and providing the right information and services to them. Were (2007) found that lack of access to information exposes adolescent girls to teenage pregnancies. Further, the study findings are in line with Kinaro (2012) who found that health care providers are opposed to adolescent contraception and instead advocate abstinence. This gives weight to the fact that there is need for health service providers as the custodians of the right information and services to embrace an open attitude towards the subject matter. Service providers should champion awareness on reproductive health rights, sensitize adolescents and the community on behaviour change as agents of change, and act as reference focal persons for adolescents.

5.3 Conclusion

This study sought to access adolescents' attitudes towards the provision and use of contraceptives as well as the factors that influence those attitudes in Kamukunji Constituency, Nairobi City County using the descriptive approach. In the light of the findings, the study concludes that adolescents' are sexually active and, therefore, need information on the provision and use contraceptives to deal with the problems of early pregnancies and the possibility of being infected with STIs. In addition, social networks are an important factor in the provision and use of contraceptives by adolescents.

5.4 Recommendations

On the basis of the conclusions, the study makes the following recommendations:

1. Adolescents should be provided with the necessary information on the provision of and use of contraceptives so that they can make informed choices about their reproductive health.
2. Adolescents should be mainstreamed in awareness and advocacy platforms that seek to change societal attitude towards provision and use of contraceptives.
3. Further studies on the subject should be done in other areas of the City County to see if there are any similarities or differences in the attitudes of adolescents in these areas towards provision and use of contraceptives.

REFERENCES

Africa Population and Health Research Centre (2014). *Population and Health Dynamics Report In Nairobi's Informal Settlements: Report on Nairobi Cross-Sectional Slum Survey 2012.* Nairobi: Africa Population and Health Research Centre.

Berenson A.B., Z.H Wu., C.R. Breitkopf and J. Newman (2005). The Relationship between Source of Sexual Information and Sexual Behavior among Female Adolescents. *Contraception*, 73:274–8. Available at: https://www.contraception journal.org/article/S0010-7829(05)00322-7/. Accessed on 9th March, 2019.

Center for Reproductive Rights and United Nations Population Fund (2010). *The Right to Contraceptive Information and Services to Women and Adolescents.* New York: Center for Reproductive Rights.

Ernst, K. (2018). *Birth Control Implant*. Available at https://www.healthline.com/health/ Birth-control-implant. Accessed on 9th March, 2019.

Evans, N., Gilpin, E., Farkas, A.J., E. Shenassa and J. P. Piere (1995). Adolescents' Perception of their Peers' Health Norm. *American Journal of Public Health,* 85: 1064 - 1069.

Government of Kenya (2014). *Kenya Service Availability and Readiness Assessment Mapping (SARAM).* Nairobi: Ministry of Health.

Government of Kenya (2010). *Kenya 2009 Population and Housing Census Highlights*. Available at https://www.scribd.com/doc/36672705/Kenya-Census-2009. Accessed on 12th September 2019.

Information Cradle (2015). *Kamukunji Constituency*. Available at https://information cradle.com/kenya/kamukunji-constituency/. Accessed on 9th April, 2019.

Jaccard, J. and Dittus P.J. (2000). Adolescents' Perceptions of Maternal Approval of Birth Control and Sexual Risk Behavior. *American Journal of Public Health, 90*(9):1426–1430.

Kabiru, C. W. and Orpinas, P. (2009). Factors Associated with Sexual Activity among High School Students in Nairobi. *Journal of Adolescence, 32* (4): 1023-1039. 10.

Kaggikah, Don (2017). *Nairobi County – 047.* Available at https://www.kenyacounty guide.co.ke/nairobi-county-047/. Accessed on 10th May, 2019.

Kenya National Bureau of Statistics (2010). *Kenya Demographic and Health Survey: Family Planning*. Nairobi: Government Printer.

Kenya Human Rights Commission and Reproductive Health and Rights Alliance (2010). *Teenage Pregnancy and Unsafe Abortion: The Case of Korogocho Slu*ms. Nairobi: Kenya Human Rights Commission.

Kinaro, J. W. (2012). *Adolescent Perceptions towards Contraceptive Use in Nairobi.* Available at http://erepository.uonbi.ac.ke/. Accessed on 7th March, 2019.

Kirby, D. (2007). *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases.* Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.

KNBS (2009). The 2009 *Kenya Population and Housing Census.* Available at https://www.knbs.or.ke/constituency-population-by-sex-number-of-households-area-and-density/. Accessed on 8th June, 2019.

KNBS (2010). *Economic Survey: 2011 Highlights*. Nairobi: Government Printer.

KNBS and ICF Macro (2010). *Kenya Demographic and Health Survey, 2008-09.* Calverton, Maryland: KNBS and ICF Macro.

KNBS and ICF Macro (2014). *Kenya Demographic and Health Survey*. Rockville, Maryland: KNBS and ICF International.

Marcus, R. and Harper, C. (2015). *Social Norms, Gender Norms and Adolescent Girls: A Brief Guide.* Available at https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9818.pdf . Accessed on 9th March, 2019.

Mehta, M. and Malhotra, A. (2000). *Adolescent Reproductive Health in Nepal using Participatory Methods to define and respond to Needs*. New York and Washington, DC: AVSC International.

Miano, M. and Mashereni, S. (2014). *Knowledge, Perception, and Information that Kenyan Adolescents have Regarding the Use of Contraceptives*. Available at *http://erepository.uonbi.ac.ke/*. *Acc*essed on 7th March, 2019.

Miller, D.T. and McFarland, C. (1991). When Social Comparison Goes Awry: The Case of Pluralistic Ignorance. In J. Suls and T. Wills (Eds.). *Social Comparison: Contemporary Theory and Research*, pp. 287-313. Hillsdale, NJ: Lawrence Erlbaum Associates.

Motherhood101 (2016). *Types of Contraception*. Available at https://www.kenyacounty co.ke/category/getting-pregnant/contraception/types-of-contraception/. Accessed on 9th March, 2019.

Mumah, J., C.W. Kabiru, C. Izugbara and C. Mukiira (2014). *Coping with Unintended Pregnancies: Narratives from Adolescents in Nairobi's Slums*: *STEP UP Research Report*. Nairobi: African Population and Health Research Centre.

Munene, L. (2015). *Factors Influencing Use of Contraceptives among Sexually Active Adolescents in Nairobi County's Non-Formal Settlements: The Case of Adolescents in Majengo Sub-County.* Available at http://erepository.uonbi.ac.ke/. Accessed on 7th March, 2019.

National Gender and Equality Commission (2016). *Lost Childhood: Drivers of child pregnancies in Kenya*. Available at https//www/ngeckenya.org/Downloads/Lost%20Childhood%20Drivers%20of%20Pregnancy%20in%20Kenya.pdf. Accessed on 9th August, 2019.

National Government Constituency Development Fund (2015). *Kamukunji Constituency*. Available at https//www/mgcdf/go.ke/index.php/2015-07-28-04-03-42/ Constituency/288-kamukunji. Accessed on 10th May, 2019.

NHS (2010). *Your Contraception Guide: What is Contraception?* Available at https://www.nhs.uk/conditions/contraception/what-is-contraception/. Accessed on 7th March, 2019.

Perkins, H.W. (2003a). *The Promise and Challenge of Future Work on Social Norms Model.* San Francisco, CA: Jossey-Bass.

Perkins, H.W. (2003b). *The Promise and Challenge of Future Work on the Social Norms Model. Chapter 17 in HW Perkins (Ed). The Social Norms Approach to Preventing School and College Age Substance Abuse: A Handbook for Educators, Counselors, Clinicians*. San Francisco, CA: Jossey-Bass.

Perkins, H.W. (Ed.) (2003c). *The Social Norms Approach to Preventing School and College Age Substance Abuse*. San Francisco, CA: Jossey- Bass.

Planned Parenthood (2010). *Birth Control: WHAT are the Benefits of using Condoms?* Available at https://www.plannedparenthood.org/learn/birth- control/condom/ what-are-the benefits-of-condoms. Accessed on 7th March, 2019.

United Nations Population Fund (2010). *Right to Contraceptive Information and Services for Women and Adolescents.* New York: United Nations Population Fund.

United Nations Children's Fund (2013). *Towards an AIDS-Free Generation-Children and AIDS.* Sixth Stock Taking Report. New York: UNICEF.

USAID (2019). *Kenya: Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Women (DREAMS).* Available at https://www.usaid.gov/sites/default/files/documents/1860/DREAMS_fact_sheet_2019.pdf. Accessed on 27th September, 2019.

Valentine, O., O. Frank and E. O. Friday (2001). Why Nigerian Adolescents seek Abortion Rather: Evidence from Focus-group Discussions. *International Family Planning Perspective,* 27 (2): 77-81.

Were, M. (2007). Determinants of Teenage Pregnancies: The Case of Busia District in Kenya. *Science Direct,* 5(2): 322–339.

Williamson, L.M., A. Parkes, D. Wight, M. Petticrew and G.J. Hart (2009) Limits to Modern Contraceptive Use among Young Women in Developing Countries : A systematic Review of Qualitative Research. *Reproductive Health*, 6(3). Available at https://reproductive-health-journal.biomedcentral.com/articles/10.1186/1742-4755-6-3. Accessed on 10th May, 2019.

Wind, R. (2005). *New Studies Signal Dangers of Limiting Teen Access to Birth Control Information and Services*. Available at https://guttmacher.org/media/nr/2005/01/18/index.html. Accessed on 10th March, 2019.

World Health Organization (2014). *Family Planning.* Available at http://www.who.int/reproductivehealth/topics/family_planning/unmet_need_fp/en. Accessed on 10th March, 2019.

World Health Organization (2013). *WHO Media Center*. Available at http://www.who.int/mediacentre/factsheets/fs110/en/. Accessed on 10th March, 2019.

Zulu, E., F. Dodoo, and A. Ezeh (2002). Sexual Risk-taking in the Slums of Nairobi, Kenya. *Population Studies, 56:* 311-323.

APPENDICES

Appendix 1: Consent Form

My name is **Mercy Njoki Gichengi** a student at the Institute of Anthropology, Gender and African Studies, University of Nairobi. I am conducting a study on **"Adolescent Attitudes towards the use of Contraceptives to Adolescents in Kamukunji Constituency".**

Purpose

The study seeks to find out the factors that determine provision and use of contraceptive by adolescents residing in Kanuku and Kinyago informal settlements, Kamnukunji Constituency.

Risks/Harms/Discomforts Associated the Study

The research has the potential to introduce psychological, social, and emotional risks. Efforts will be put in place to minimize the risks. One potential risk of being in the study is loss of privacy. Answering of questions in the interview may be uncomfortable for you. If there are any questions you do not want to answer, you can skip them. The researcher will ensure privacy.

Discussing some things in a group discussion set up or recalling some events may be stressful. In case of any emotional or psychological trauma related to this study, contact the Researcher right away at the number provided at the end of this document.

Confidentiality

Outmost confidentiality will be maintained at all times during the research as well as with information collected. There will be no names mentioned mentions in the report or publications arising from the study.

Benefits Being in this Study

There are no direct benefits to you individually as a participant. However, the information you provide will help us better understand adolescents' attitudes towards provision and use of contraceptives in Kamukunji Constituency. This information may inform design, development and implementation of an adolescent – friendly environment in the community.

Cost of being in the Study

This study will not cost you anything but your time. All materials related to the study will be provided for by the researcher. There will be no payments made for being part of the study.

Contact persons

If you have any questions or concerns regarding the study, you can contact me on **0723577403.** Your decision to participate in research is voluntary and will be highly appreciated. If you agree to participate in the study please sign below.

Signature/Thumb ……Date ……

Appendix II: Semi-structured Questionnaire

Questionnaire number: …… Date of the interview…….

Ward……. ….. Cell phone no: …….

1. Bio Data

a. Age ……..

b. Gender……..

1. How many siblings do you have? ..... (Explore for birth order and gender of the siblings?

2. What is your level of education (tick appropriately)
    i. Primary school
    ii. Which grade/class are you in?
    iii. Secondary school
    iv. Which level? (Form 1, Form 2, Form 3, or Form 4)
    v. Out of school? (Explore for the level they dropped out of school at and the reasons).
3. If out of school what do you currently do? (Explore on marriage, work, children etc.)

II. Attitudes towards provision and use of contraception

4. Who do you admire? (Kindly mention your relationship to them)

5. Whose opinions are important to you in terms of your school and general life?

6. Whom do you trust to discuss challenges related to sexual and reproductive health, including contraceptives?

7. Whose advice or opinions influence the information that you trust and share with friends and others?

8. In the last six months, has a concern about what other people would think influenced your decisions about how and where to seek help on contraceptives as an adolescent? If yes, whose opinion and how has it influenced your decision?

9. I am going to read through some behaviour, and you should tick on the boxes below if you have personally experienced it.

Behavior	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
Adolescents would like to have information about contraceptives that are available					
Adolescents are sexually active					

Adolescents seek for contraception information from service providers					
Adults encourage adolescents to ask questions about contraception					
Health service providers encourage adolescents to ask questions about contraception					
Adolescents are talked to about contraception					
Adolescents are provided with contraception by service providers					
Adolescents access contraceptive services easily					
Adolescent are open to using contraceptives					

Appendix III: Key Informant Interview Guide

A. Bio data (indicate if applicable)

Gender: …… Age: ……

Occupation: ……

1. Level at which you are involved with adolescents sexual and reproductive health issues.

2. Have you interacted or worked with adolescents in Kamukunji Constituency? If yes, for how long and in what capacity?

3. Have you been involved in provision of contraceptives to adolescents in the constituency

B. Provision and use of contraception by adolescents

4. How do you perceive adolescents attitude towards provision and use of contraceptives in the Kamukunji constituency? Kindly elaborate.

5. What do you think are the major factors affecting the provision and use of contraceptives by adolescents?

6. In your opinion
   a. How can we address these attitudes?
   b. How can we address these factors?

7. Do you have any other comment?

Appendix IV: Focus Group Discussions Guide

Date……

Gender of group……..

Number of participants……..

1. Perceptions on provision and use of contraceptives by adolescents.

2. Adolescents in this community that have been able to access contraception.
3. Challenges that adolescents face while trying to access contraception information and services.
4. Ways in which these challenges can be addressed.

Appendix V: NACOSTI Research Permit

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **592427**

Date of Issue: **09/September/2019**

RESEARCH LICENSE

This is to Certify that Ms.. Mercy Gichengi of University of Nairobi, has been licensed to conduct research in Nairobi on the topic: ADOLESCENT ATTITUDES TOWARDS THE PROVISION AND USE OF CONTRACEPTIVES IN KAMUKUNJI CONSTITUENCY, NAIROBI CITY COUNTY for the period ending : 09/September/2020.

License No: **NACOSTI/P/19/1101**

592427

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

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