MODERN CONTRACEPTIVES CONVERSATIONS AMONG SEXUALLY ACTIVE YOUTH IN KIANDA WARD, KIBRA NAIROBI

OMBAMBO ELIZABETH OCHANDA

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DECLARATION

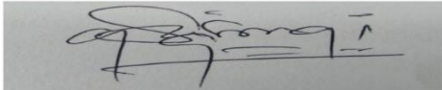
This research project is my original work and has not been presented in any other university.

Signature: Date: 20/11/2020

Ombambo Elizabeth Ochanda

K50/11451/2018

This research project has been submitted for the award of degree of Master of Arts in communication studies, with my approval as the University Supervisor.

Signature:  Date: 20/11/2020

Dr. Samuel Siringi

DEDICATION

I dedicate this research project to my late parents, Lucas Ombambo and Benta Achieng who always encouraged me to work hard for a better tomorrow. To my nieces Vivian, Maggy and Terry who look up to me as a role model for my family and friends for wishing this achievement for me; to my partner Alex Muga for his encouragement and finally to my son Myles Hawi Muga, who will be only 15 days on the day of the graduation, he was my main inspiration for this achievement.

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LIST OF ABBREVIATIONS

AMREF	Africa Medical Research Foundation
BTL	Bilateral Tubal Ligation
CPR	Contraceptive Prevalence Rate
FGDs	Focus Group Discussions
FP	Family Planning
FPAK	Family Planning Association of Kenya
ICPD	International Conference on Population and Development
IMR	Infant Mortality Rate
KDHS	Kenya Demographic Health Survey
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NCPD	National Council for Population Development
WHO	World Health Organisation
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SRH	Sexual Reproductive Health
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WRA	Women of Reproductive Age
FS	Female Sterilization
MC	Modern Contraceptives
MM	Mass Media

MMR	Maternal Mortality Ratio
PSK	Population Services Kenya
SN	Social Networks

ABSTRACT

The study sought to investigate how sexually active youth in Kibera's, Kianda Ward communicate among themselves regarding adoption and use of modern contraceptives. The objectives of the study were to analyze modern contraceptive conversations among sexually active youth in Kibera's Kianda Ward; to analyze sources of information on modern contraceptives among sexually active youth**;** to examine the key messages contained in conversations among sexually active youth regarding adoption and use of modern contraceptives; to investigate factors that hinder adoption and adherence to modern contraceptives use among sexually active youth. The study deployed the Theory of Social Constructivism which is instrumental in gaining deep insights on how relationships and social interactions inform day to day decisions and behaviour. Understanding how social interactions impact decision making can also guide development, testing and contraceptive interventions which operationalizing on angles such as conversations among sexually active youth. The Theories adaptability and comprehensiveness and its' social leaning support its use in health communication in that Modern contraceptives services providers can use it to grasp sexually active youth clients' modern contraception needs through enhancing conversations on modern contraceptives. The study applied descriptive research design and qualitative research approach that are effective for purposes of acquiring of in-depth knowledge of a subject using a small sample. The target population for the study were 100 sexually active youth who sought modern contraceptive services at Ushirika Health Centre, in Kianda area, Kibra Constituency of Nairobi County, between January and April 2020. The sampling frame was the listing of all the youth who sought the services within the period as contained in the facility's register. Data was collected from two Focus Group Discussions of ten youth each and interviews with 10 youth all sampled through convenience sampling. Key informant interviews were conducted with four health centre staff selected through purposive sampling. Document analysis was used to study key documents at the health centre. Thematic analysis was done based on the objectives while data is presented using descriptions and narrative format. The study established that a majority of sexually active youth do not always have conversations on modern contraceptives with their partners, for those who do, the conversations usually comes after an unplanned pregnancy has already happened or they have had an experience of unplanned pregnancy from previous relationship(s). The study also established that sexually active youth are fairly knowledgeable on modern contraception, however, this knowledge does not always translate to adoption and adherence to the commodities use. The study also revealed that most barriers to modern contraceptive use are as a result of myths and misconceptions they get from the community regarding the contraceptives. The study recommends establishment of youth friendly centres to enable the youth to comfortably seek contraceptive services. The study also recommends tapping on social media to constantly pass information on modern contraceptives to encourage sexually active youth normalize talks on modern contraceptives which will in turn encourage adoption and use contraceptive education also needs to be incorporated in reproductive health education preferably before onset of puberty so that the youth can make informed decisions regarding adoption and use.

CHAPTER ONE: INTRODUCTION

1.1 Overview

This chapter focuses on the background of the study that highlights population rates and family planning efforts globally, in the Sub-Saharan Africa and Kenya. Problem statement that shows the existing gap being examined. The chapter also highlights research objectives, questions to be answered in the study and explains the rationale and justification of the study. It also gives information on the scope and limitation of the study. The chapter also elaborates on a few terminologies and their meaning as used in the study.

1.2 Background of the Study

Over the years' contraceptive uptake has significantly increased worldwide, moreover in Asia, Europe and Latin America, but the trend continue to pick up slowly in Africa. Globally, use of modern family methods slightly increased, from 55% in 1992 to 58.6% in 2018. In Africa, the percentage of women of reproductive age who reported to be using modern contraceptive methods increased minimally in the year 2008 and 2018. In Sub-Sahara Africa, the percentage slightly from 23.6% to 28.5%, in Asia it rose between 60.9% to 61.8% in years under review while America in the Caribbean and the Latin, it has stabilized at 67.6%. (Global Population watch report, 2018).

Many 3rd World countries or growing economies experience rapid population growth that is linked to high number of children women in the countries give birth to compared to those with high modern contraceptive adoption rate (high fertility rates), high number of live births/1000(Fertility rates) boasted by significant declines in number of deaths, low number of women of reproductive age on contraception or whose partners are on contraception(contraceptive prevalence rate) and reducing death rates (Oyedokun, 2007).

As at the year 2007 Sub-Saharan Africa was experiencing the highest rate of population growth at five percent. The number of people in need of education, health and other social services is ever increasing hence putting a strain to the limited infrastructure and available resources. This is la major impediment to the reduction of child deaths, improvement of the health of mothers, and other Millennium Development Goals (USAID/HPI, 2007). It was to address these challenges that many countries in Africa focused their attention on birth control measures, particularly the use of family planning. Kenya was among these pioneers.

Kenya was the first nation to adopt a rigorous national family planning strategy in 1960. This was as a result government's desire to reduce population growth increase to ease pressure on scarce resources and to accelerate attainment of the Government's post-independence goal of eliminating ignorance, disease and poverty. This did not however solve the problem as population increase remained steady as the country was still reporting the highest number of births in the world at that time standing at nine births per woman, which resulted in 4% population increase per year.

After a decade of experimenting with the program, which enjoyed massive support from the international donor, the program began to bear fruits despite it being popularly labelled as being of no impact (Lapapham & Mouldin 1984; Mouldin & Benson, 1978). Fertility rates began to drop significantly to decline (Nobbe & Kelly 1992; Robinson, 1990). Family planning programs have picked momentum and enjoy high political good among top institution in Kenya and among the international development partners in health. However, the Kenya Demographic Health Survey (KDHS, 2014) established that women in rural and slum settings have at least one child more than their counterparts in urban settings. The

objective is to analyze modern contraceptives conversations among sexually active youth aged 19-35 years in Kianda, Kibra.

1.3 Problem Statement

Kenya's long-term development plan/strategy, Vision 2030 a targets to create a world class economy whose citizens have high quality lives by the year 2030. It aims to create more industries and create a middle-income country providing a high quality of life to all Kenyans citizens and ensure a hygienic/clean and safe environment for all. Kenya is also committed to the United Nations, Sustainable Development Goals SDGs (vision 2030.go.ke). The Government also aims to deliver Universal Health Coverage (UHC) by 2022, this means that every Kenyan should have access to quality and affordable healthcare i.e. no Kenyan should suffer financial loss while trying to get treatment and or medication. (Universal Health Coverage Roadmap; MOH, 2017).

Suboptimal family planning is leading to poor scores in maternal and child health indicators with maternal mortality ratio and the neonatal death rate in Kenya standing at 365/100,000 births and 24/1000 births. Women are dying because of abortion due to unplanned pregnancies, families are having children they cannot comfortably cater for, leading to low scores in children health indicators resulting to high number of deaths among children. This is an impediment to attainment of Millennium Development Goals 4.1 and 4.2 of reducing of reducing under five and infant mortality and MDG Goal 5.1 of reducing maternal mortality. Kenya's population is estimated to increase by one million annually (DSW, 2014). Rapid population growth is a major impediment to most government goals. Despite years of efforts by the Government of Kenya and development partners in health to provide family planning services and to encourage adoption of modern contraceptives,

adoption rates among sexually active youth partners living in low-income areas are still poor leading to unintended pregnancies among the youth. The Kenya Demographic Health Survey (KDHS, 2014) and Kenya Population Based HIV Impact Assessment Survey (KENPHIA, 2018) revealed that unintended pregnancies among the youth was at still high with the youth in urban slums recording the highest percentage of cases. Youth from the slums were found to be more likely to have unintended pregnancies (33percent) than youth from the wealthiest households (10 percent).

Slum dwellings limit the reproductive choices of sexually active youth. The dwellings are characterized by poverty and poor living conditions, youth in these areas are also exposed to sex earlier than the youth in other settings, limited access to reproductive health services, illiteracy, sexual violence, and limited of access to quality health care, including ante and post-natal care services. The slums present potential grounds for unplanned pregnancies

A study by Population Service Kenya (PSK) established that teenage girls/ younger women in Kenya are at a higher risk of getting unplanned /untimed unwanted pregnancies. However, adoption of family planning or modern contraceptives among this population remain worryingly low. Unintended pregnancies lead to unsafe abortions which leads to high Maternal Mortality Rates and high Infant Mortalities Rates due to lack of access to proper nutrition and healthcare services. Despite these compelling evidence showing that early sex debut, high rates of abortion, unmet need for family planning and unintended pregnancies are rampant in the informal settlements, the area has not attracted much scholarly attention in what can likely point out the amount of conversations/ information/messages and/or communication that exists among the youth in the areas. This study therefore seeks to

investigate how sexually active youth communicate among themselves around the issues of family planning with a focus on modern contraceptives.

1.4 Objectives of the Study

The general objective was to analyze modern contraceptive conversations among sexually active youth while the specific objectives were;

i. To analyze sources of information on modern contraceptives among sexually active youth
ii. To examine the key messages contained in conversations among sexually active youth regarding adoption and use of modern contraceptives.
iii. To investigate factors that contribute to or inhibit the use of modern contraceptives among sexually active youth.
iv. To examine sexually active youth attitudes towards modern contraceptives

1.5 Research Questions

i. What are the sources of information on modern contraceptives among the youth?
ii. What are the key conversations and messages among sexual partners on adoption and use of modern contraceptives?
iii. What are the factors that encourage use of or hinder adoption of modern contraceptives among sexually active youth?
iv. What are the attitudes of sexually active youth partner to modern contraceptives?

1.6 Rationale of Study

The Sixth Edition of the National Family Planning Guidelines by the Ministry of Health (2015) recognizes that barriers to Family Planning disproportionately affect certain populations among them the urban poor. Unintended pregnancies among the youth in slums

is still considerably high. The question on whether sexually active youth in urban slums engage in conversations about modern contraceptives has not received much attention in Kenya and Africa in general.

The study thus seeks to establish whether sexually active youth talk about modern contraceptives and the extent to which the talks affect adoption and use. The findings can help the Government and development partners in family planning policy and strategy formulation to encourage adoption of modern contraceptives among sexually active youth. The World Health Organisation approximates that 92% of pregnancy termination-related deaths and 23% of pregnancy-related disabilities and deaths, along with 34% of deaths of mothers, could be avoided by proper use of modern contraceptive products (WHO, 2017). Findings from the study can also set a stage for further research in this area given that the area is quite novel.

This will facilitate availability of knowledge in the area. Increase in adoption of modern contraceptives among sexually active youth especially in the urban slums will reduce population growth. Reduced population will ease provision of services thereby ensuring quality of life leading to improved lives. Adoption of modern contraceptives will also prevent unintended pregnancies thus reducing deaths from unsafe abortions. Planned families will also ensure healthy children thereby reducing infant and under five mortalities. This will accelerate achievement of Universal Health coverage (UHC), vision 2030 and Sustainable Development Goals (SDGs).

Encouraging conversations among sexually active youth partners on adoption of modern contraceptives will be crucial for decision making on the adoption of appropriate modern contraception. Increasing adoption of modern contraceptives and decrease in fertility

rate in urban slums would help reduce rapid population growth by preventing unplanned conception and the consequences thereof while improving on the quality of life.

1.7 Significance of Study

The study will help understand whether sexually active youth talk about modern contraceptives and the content of such communications. This can guide development of programs and messages to encourage such conversations, which may enhance adoption of modern contraceptives leading to curbing of unplanned pregnancies among sexually active youth. Best practices and gaps identified by the study will help the Government and development to better package messages to encourage adoption of modern contraceptives among sexually active youth.

By preventing unintended pregnancies, the use of contraceptives reduces maternal and infant deaths. Modern Contraceptives will also allow sexually active youth to be in control of when to have children, to decide the number of children they wish to have also spacing of the children, ensuring that youth get children when they can comfortably cater for their needs in terms of food, shelter, clothing and education thus reinforcing their reproductive rights.

Contraception is paramount in slowing unrealistic population growth and the resultant effects on economies, environment, and local, regional and international development agenda/efforts. Current US Census Bureau world population estimates in June 2019 shows that the global population is at 7.6 billion. Sub-Saharan Africa has the fastest population growth rate in the world, at 2.8 percent annually with the trend expected to double by 2030 before fertility rates begin to decline (US Census Bureau, 2019). The ever-growing population is strenuous to governments struggling to distribute already scarce resources.

The World Health organization (WHO) estimates that 214 million women in 3rd world /developing countries have difficulty accessing family planning services. Modern Contraceptive methods like use of condoms also prevent sexually transmitted infections such as HIV, syphilis among others. Use of modern contraceptives prevents unwanted pregnancies thereby reducing the need for unsafe abortion.

1.8 Scope and limitations

The study was limited to the Kianda area in Kibera and focused only on Ushirika Health Centre that provides free family planning services for the youth as opposed to others that charge. The sampling frame was limited to the clients who sought modern contraceptive services between January and April 2020 as per the facility's register. The study also applied qualitative research approach and descriptive research design, which means that a small sample size was used and one may argue that the findings may not be inferred to a general population. Little research has been done regarding conversations on modern contraceptives among sexually active youth thus the study had limited body of knowledge for comparison. Respondents were drawn from the sexually active youth partners aged 18-35 as opposed to the entire reproductive age bracket (15-49 years).

1.9 Operational Definitions

Conversation is a talk between two or more people, in which news and ideas are exchanged

Youth refer to male or female aged 18-35 who seeks contraceptive use

Contraceptive uptake refers to reported picking or buying use of a contraceptive.

A contraceptive method of choice is a contraceptive method that a sexually active youth reported to prefer at the time of collection of data.

Contraceptive use refers to the reported actual use of contraception.

Contraceptive pill is a contraceptive in the form of a pill used to inhibit and so prevent conception leading to pregnancy.

Contraceptive prevalence rate is the percentage of women of reproductive age using contraception method or whose partners are using a contraceptive method at a given point in time" (WHO, 2008)

Condom is a contraceptive device consisting of a sheath of thin rubber or latex worn over the penis during intercourse.

Infant Mortality Rate is the death of children under the age of one year.

Intra-uterine device is a device consisting of a piece of bent plastic or metal that is inserted through the vagina into the uterus.

Maternal Mortality refer to deaths due to complications from pregnancy or childbirth

Message Analysis is a detailed examination of contraceptive messages

Modern Contraceptives are drugs or devices used to prevent women from conceiving excluding natural methods like withdrawal and rhythm.

Morning-after pill is a large dose of estrogen taken orally within 24 or 72 hours after intercourse: prevents implantation of a fertilized ovum and hence acts as a contraceptive.

Unmet need for family planning refer to the percentage number of people who are in need of contraception but cannot access it.

Sexual partner is a man and a woman who has a long term or short-term sexual engagement with a person of opposite.

Traditional contraceptive method is a method that consists of withdrawal before ejaculation or periodic abstinence otherwise known as the calendar method.

Youth is defined as a male or female aged 18-35.

CHAPTER TWO: LITERATURE REVIEW

2.1 Overview

This chapter highlights the literature related to modern contraceptives. It discusses sexually active youth conversations on modern contraceptive, sources of information on modern contraceptives among the youth factors that encourage or hinder adoption and use of modern contraceptives among sexually active youth and sexually active youth attitudes towards modern contraceptives.

2.2 Sexually Active Youth Conversation and Modern Contraceptives

The role of conversations among sexually active partners is always highlighted in modern contraceptives strategies planning and inquiry and research. Researches insist that the conversation is key to decision making regarding adoption and use of modern contraceptives. A number of scientific inquiries have identified a positive connection between the amount of conversation on modern contraceptives between sexual partners and adoption of modern means of family planning. Such conversations however, especially in in struggling economies needs to be encouraged by governments and development partners in health as they remain rare. There is need for development and implementation of program interventions to encourage sexually active youth to talk about the number of children to have, birth spacing and contraceptive use. Since relatively little is known about how conversations regarding modern family methods affects decision making among sexually active youth, there is need for more scientific inquiry/research/ studies on the processes and outcomes.

This will be important for both programmatic and theoretical reasons. The objective of this research to establish whether sexually active youth in Kibera's, Kianda Ward have conversations regarding modern contraceptives and whether such conversations lead to

adoption of the contraceptives specifically, the inquiry aim to expose the link between sexually active youth conversations on modern contraceptives and the adoption and use of the commodities.

The World Health Organization approximates that over 210 million pregnancies happen annually, a third of them being unintended. Most unplanned pregnancies result to stillbirths due to poor ante-natal Care (ANC), miscarriages, and unprofessional abortions which results to either death or undesirable reproductive challenges on a woman. (WHO, 2011). A report by WHO also indicate that six million women are treated every year for complications arising from crude /backstreet abortions.

Encouraging effective contraceptive practices among sexually active youth will lead to high scores in maternal health indicators, increasing child survival rates, and result to girl child empowerment. For this to be realized sexually active youth need to easily access contraceptive services that are not only friendly but also safe and effective.

Ensuring effective Family planning will help eliminate unwanted/untimed/unplanned pregnancies among women of reproductive age. Thus, improving the health of children and women which is key to achieving the Millennium Development Goal (MDG) (WHO, 2007). Effective contraception helps prevent high risk pregnancies a key factor in planning a family is healthy timing and spacing of pregnancies (HTSP). Which empowers sexually active partners to have the desired number of offspring that they can comfortably cater for in terms of food, shelter, clothing and education. This leads to healthier and educated families hence productivity and improved economies.

It is estimated that a large percentage of abortion-related (90%) and a significant percentage of pregnancy-related (20%) disability and an equally huge percentage (32%) of

reproductive women deaths, can be eliminated by proper Family Planning Practices. In third world countries, many married women have limited or lack access too reproductive health services. A woman has unmet need for contraception if she is capable of bearing children/fertile, sexually active not using any modern method to prevent conception yet she has no intention of conceiving in the next at least two years (spacing) or does not want more children (Hossain et al., 2015.)

The lack of access to proper Family Planning Services was the key highlight for the International Conference for Population and Development (ICPD), as "each government's goals for Reproductive Health should be measured in in the scale of access or lack of access to contraceptive (UN, 1994) and that all countries should, over the next several years, measure the extent of national unmet need for good-quality family planning services. (ICPD 1994&2019 communiqué). The ICPD aimed at reducing the unmet need for contraception by 50% by the year 2005 and totally eliminating the need by 2015. The call to action was a revitalization of the agenda and political support/ goodwill called for to incorporate family planning into the development blue print.

Studies have shown that availability of information or widespread knowledge concerning family planning and proper interaction with service providers, mental health status, class, sexual leaning, marital status, total health status, race, gender, ethnicity, religion, education, income, family size, sex (demographic characteristics,) can also affect the selection of a modern contraceptive method (McCauley et al., 1994). Lack of consent to on adoption and use among sexually active partners, worrying about possibility of side effects, fear of health complications concerns, and claims of lack of enjoyment due to lack of

sexual sensation when using them have been adversely mentioned as major inhibitors to the adoption and adherence to use of modern ways of preventing conception.

2.3 Barriers to Adoption of Modern Contraceptives

Ignorance of modern ways of preventing conception and their mechanism of action has been cited largely as one of the major reasons for the non-use of modern contraception by women (Sajid et al., 2010). Due to lack of reproductive health knowledge among sexually active teenagers and youth, they are unaware of their fertile days, as a result they engage on unsafe sex on those days leading to unwanted pregnancies (Sedgh, 2010).

A study by Jeff (2015) established that barriers to adoption modern contraceptives included ignorance, fear of health issues associated with the commodities, religious beliefs and lack of consent among sexual partners. Lack of spacing and limiting was high (22 & 32%). For majority (57%); pregnancy spacing met WHO's Healthy Timing and Spacing of Pregnancy recommendations. Encouraging of family planning was poor (43%). The study recommended that to accelerate adoption of Modern Contraceptives, capacity building of modern contraceptives service providers, an encouraging sexually active couples to adopt modern contraception, improving modern contraceptive services in all public/ private health facilities and encouraging adoption of Modern Contraceptives on each contact of women needed to be emphasized (Health, 2011).

The importance of male sexual partners supports in the adoption and use of modern contraceptives cannot be overemphasized. Inquiries have revealed that male sexual partners' involvement in modern contraception conversations and decision making does acceptance of modern birth control, client satisfaction, effective birth control practices, and sticking to use

of birth control methods. Male sexual partners' opposition has been cited as the main hindrance in the use of modern birth control methods in the cohort of sexually active youth.

Studies have also revealed that apart from male sexual partners' support, peers, influencers like the parents of sexual partners and people the youth look up to in the community in the communities are also key in influencing decisions of whether to adopt or not to adopt and or adhere to modern ways of birth control among sexually active youth. Sexually active youth are stand a high chance of adopting and using modern methods of birth control if their opinion leaders speak positively to them regarding the commodities. Inquiries have strongly linked conversation among sexually active partners regarding modern contraceptives and adoption and sticking to the modern ways of birth control. The constant conversations between sexually active partners about adoption of modern means of birth control and the proper timing of pregnancy and the desired number of children is tightly connected to successful contraceptive use.

2.4 Benefits of Using Modern Contraceptives

Scholarly inquiries have revealed that family planning, including decisions on the number of children to have, decisions on whether and when to have children, is connected to high scores for child health indicators, either directly on the babies or through observance of healthy practices by women when they are pregnant for example visiting clinics, observing cleanliness and being keen on proper diets.

Modern ways of birth control have a myriad other advantages a part from their universal intention of prevention conception. Proper use of birth control commodities prevents related disabilities and deaths, limits the risk of cancers of reproductive system, and can also limit or eliminate many reproductive system illnesses for both men and women.

In addition to births control education, information and services, those who visit clinics for these services also benefit from other services for example talks on nutrition, hygiene, male and female cancer prevention all of which is useful in improving health outcomes. Family Planning client's diseases are also treated to information on prevention, screening and treatment for conditions for example, Human Immunodeficiency Virus (HIV), gonorrhea, Human Papilloma Virus (HPV) cervical cancer and chlamydia.

From the clinics sexually active partners can also benefit from tips on how to address sexual or gender violence, all this information is of considerable importance to female and male sexually active youth who seek modern contraceptive services in both private and public health facilities. Since inquiries have revealed that sexually active youth do not have equal access to birth control services, the Government and concerned development partners need to put in place appropriate policy measures and strategies to ensure equal and easy access to the services and commodities by all sexually active men and women of reproductive age.

2.5 Family Planning Globally

Across the World Rigorous Family Planning programs / strategies have resulted to positive results over the past decades; with over half of sexually active partners in 3rd world countries now using modern methods of family planning. These has led to saving of many lives have been saved and resulting to women and children benefiting significantly leading to better health outcomes for this cohort resulting to major empowerment for them (Jeff et al., 2015). Despite the milestones in Family planning, modern contraceptive adoption and use is still notably low in some Sub-Saharan Africa countries in and the need remains considerably high in some of the world's poorest and populous economies like the Democratic Republic of

Congo (DRC). In most Africa republics, the number of sexually active women using modern family planning methods or whose partners are reported to be using the methods varies from one place to another with those in urban slums reporting considerable low adoption level, from 56% in southern Africa to 9% in the central region of African. Research has also revealed that despite sufficient knowledge on modern family planning methods among Women of Reproductive Age(WRA), the number of sexually active women reporting to be using or adhering to modern contraceptives or whose sexual partners were reported to be on modern contraceptives termed as contraceptive prevalence rate (CPR) remain low with CPR in the Democratic Republic of Congo being as low as 6.6 % in 2015 (Jeff et.al., 2015).

Family planning (FP) empowers people to have the appropriate number of children that is children they can properly take care of in terms of basic needs by proper spacing of pregnancies. It is also well known that modern contraceptives help to prevent children and mothers' deaths by reducing women's exposure to the health risks of unplanned pregnancy, childbirth, and abortion. FP gives women sufficient time to care for their infants and themselves. In 2006, the World Health Organization (WHO recommended that after giving birth, a woman should take at least two years before conceiving again and that after an abortion or miscarriage, a woman should give herself at least six months before trying to have a baby again in order to limit the risk of serious maternal, perinatal, and infant health outcomes; Healthy Timing and Spacing of Pregnancy (HTSP). A considerable number of inquiries have corroborated this recommendation.

2.6 Family planning in Kenya

Immediately after independence, the Government of Kenya started a vigorous family planning program in a bid to slow population in order to better cater for the social needs of

the citizenry compelled by the need for family planning in view of the limited social resources, the Government of Kenya adopted a family planning strategy as part of the National Planning Strategies. The aim was to reduce the fertility rate in the country hence reduce population growth (Republic of Kenya, 1965). The Association Family Planning in Kenya, FPAK aimed at availing Family Planning Commodities to all women of reproductive age, educating the public on family planning, and establishing family planning service provision centers in every major town countrywide. The strategy faced a myriad of challenges and it was not effective in the beginning as population control was not a major priority for the Government then. Large families were also seen as a measure of leadership ability so many people and especially men valued big families and family planning then had limited subscribers.

As any newly independent state, Kenya was keen on growing its economy. An industrializing state in economists' view would be facilitated by a big population, thus the government could not advocate for population growth (Chimbwete et al., 2005). Existing cultural beliefs and social structures made policies hard to be implemented. Even though adoption of modern birth control methods such as oral pills condoms, implants, sterilization and intrauterine devices have traditionally been low in Sub-Saharan Africa, adoption and adherence to the commodities has been rising (Stephenson et al., 2007).

According to the KDHS (2008-09), almost half of married women (47) percent) have difficulty accessing modern methods of birth control. A good number of sexually active women reported to be using a form of modern birth control method (37 percent of married women) whereas five percent reported to be using traditional methods such as rhythm, withdrawal and safe days. Injectable were reported to be the most popular method of modern

birth control used by a significant number of sexually active women at 23 percent. Pills came in 2nd in popularity among sexually active women at seven percent while female sterilization and periodic abstinence a tied in popularity at five percent.

2.7 Sexually Active Youth and Conversations on Modern Contraceptives

The role of conversations among sexually active partners is always highlighted in modern contraceptives strategies planning and inquiry and research. Researches insist that the conversation is key to decision making regarding adoption and use of modern contraceptives. A number of scientific inquiries have identified a positive connection between the amount of conversation on modern contraceptives between sexual partners and adoption of modern means of family planning. Such conversations however, especially in in struggling economies needs to be encouraged by governments and development partners in health as they remain rare.

There is need for development and implementation of program interventions to encourage sexually active youth to talk about the number of children to have, birth spacing and contraceptive use. Since relatively little is known about how conversations regarding modern family methods affects decision making among sexually active youth, there is need for more scientific inquiry/research/ studies on the processes and outcomes. This will be important for both programmatic and theoretical reasons. The objective of this research to establish whether sexually active youth in Kibera's, Kianda Ward have conversations regarding modern contraceptives and whether such conversations lead to adoption of the contraceptives specifically, the inquiry aim to expose the link between sexually active youth conversations on modern contraceptives and the adoption and use of the commodities.

2.8 Sources of Information among Sexually Active Youth in Slum Settings

Communication programs have been devised and implemented to encourage sexual partners to talk about whether they want children, the number of children to have, birth spacing and modern contraceptive use. Such communication programs would utilize platforms ranging from media campaigns in radios, interpersonal communication (Becker, 1999). In the most relevant form of intervention in the slums would be through radio programs such as drama since the radio is the most affordable and accessible form of media in terms of portability in that the youth can listen to the it on their phones as they go about their daily activities as such, they are able to get informed on modern contraceptive general adoption and use. Enough knowledge on modern contraceptives will enable sexually active youth to positively influence each other through interpersonal communication/ conversations. Through such conversations, sexually active youth are empowered to decide on the appropriate modern contraceptive to adopt and use.

Limited inquiries have been conducted on how sexually active youth negotiate and make reproductive health decisions particularly in regards to adoption and adherence to modern birth control methods. more inquiry needs to be done in the area to guide development of programs that will encourage sexually active youth to have conversations regarding adoption ad use of modern contraceptives which conversations will encourage adoption hence elimination unwanted pregnancies, the studies will also be important as they will serve as a repository apart from building on existing knowledge. (Blanc et al.,1996). The study aims to increase modern contraceptive use among sexually active youth by encouraging conversations.

2.9 Kenyan Youth and Unintended Pregnancies

The rate/ occurrence of untimed/unintended/unspaced pregnancies continue to be high among the Kenyan youth. The Kenya Demographic and Health Survey (KDHS, 2003) revealed that over half (52%) of sexually active unmarried girls aged fifteen to nineteen and almost half (47%) of the married women reported to have experienced an unplanned, mistimed or unwanted pregnancy. The 2008–09 KDHS showed that 43%of married women in Kenya reported their current pregnancies were unintended. Unintended conception is a major contributing factor to school dropout among girls in with about 13,000 girls dropping out of school annually associated with unplanned pregnancies.

Seeking abortion services from untrained persons or quacks leads to maternal deaths and adverse health effects on the health of a women. As at 2004, infant mortality deaths stood at 488 deaths in every one hundred thousand births. In Kenya, the determinants of prevalence and determinants of unintended pregnancy among sexually active youth is not clearly understood due to limited research in the area.

2.10 Theoretical Framework

2.10.1 Overview

The study deployed the Social Constructivism Theory which is instrumental in gaining deep insights on how day to day interactions in a social setting inform decision making and behavior. The theory social orientation can help in designing, piloting and implementing of well thought out modern contraceptive interventions operationalizing on dimensions such as conversations among sexually active youth. The theory's is adaptable to social settings and can therefore be used in clinical practice in that Family planning service providers can use them to understand clients' contraceptive needs especially sexually active

youth through enhancing conversations on modern contraceptives. It can also help Policy makers and players in Reproductive Health in designing youth friendly programs that will encourage adoption of modern contraceptives.

2.10.2 Social Constructivism Theory

Social constructivism Theory is a social cognitive theory that was designed by Russian Psychologist Lev Vygotsky. It emphasizes that learning can only take place in a communal or social setting and that learning cannot take place in isolation. That one has to be around others and to interact in order to learn. Vygotsky but trashed the idea of other theorist like Piaget and Perry who posited that learning could take place away from a social context. He argued that all learning functions are as a result of and must therefore be understood and explained within the same context. According to Vygosky (1978), learning is not just about gaining new knowledge by learners but rather a process through which learners become part of the community by way of integration through shared knowledge, values and beliefs.

According to Vygotsky a person's cultural development appears through interactions with others in the community (social level) and the individual level meaning the things one learns outside the community through interaction with the larger society either by travelling out of their normal setting and through media; first, between people (inter-psychological) and then at a personal level (intra-psychological). The implication is in that the willingness to interact and learn, memorise the lessons and utilise the lessons. This means that meaningful learning can only take place in a social context though an individual's willingness and ability to pay undivided attention, through an individual's effort to memorise the lessons, and though efforts to apply the lessons in one's day to day operations. All the higher functions

individuals' day to day operations originate from the society. The theory of social constructivism has been expanded on or improved by various other social cognitive scholars/researchers.

2.10.3 Application of Social Constructivism

Social constructivism is a sociological theory of knowledge. It states that human development is socially situated and knowledge is constructed through interaction with others. That social settings determines how individuals behave within those settings. A person's knowledge, beliefs and practises is determined by the cultural and social settings within which for example social class, religious beliefs and way of life.

Sexually active youth knowledge on modern contraceptives is determined by their interactions with other members of the community and what they hear or observe from the members. For example, barriers to adoption and use of modern contraceptives are related to the negative perceptions on the commodities by members of the community.

Sexually active youth decisions on whether to adopt not to adopt the use of modern contraceptives is also highly dependent on their interactions and knowledge they have acquired from the community, this will further influence their conversations and what forms part of such conversations.

Positive interactions and conversations on modern contraceptives can add to sexually active youth's "actual development', that is, the knowledge that the youth already have on modern contraceptives and lead to 'potential development', that is, additional information that the youth may not have. This will lead to positive reinforcement and result to adoption of modern birth control methods among sexually active youth. The opposite will happen when the community talk negatively regarding adoption and use of modern means of

contraception. Sexually active youth can also encourage each other to adopt the use of modern means of contraception if they engage in positive talks regarding the commodities but the society has a major role to influencing individuals' behaviour.

CHAPTER THREE: METHODOLOGY

3.1 Overview

This Chapter discusses the Research Design by the study, research approach, research method, sample population, sampling Frame, sampling method, data collection method, data collection instruments, ethical considerations, data analysis and data presentation.

3.2 Descriptive Research Design

Descriptive research is used for conducting research in many subjects. The aim of descriptive research is to understand and describe a phenomenon and its characteristics. This research is more concerned with the aspect rather than how or why aspects of a phenomenon or occurrence. The research design utilizes tools like observation and survey to gather data (Gall & Borg, 2007). This method deploys data collection tools such as Key Informant Interviews, Focus Group discussions, individual interviews and document analysis.

3.3 Qualitative Research Approach

The study adopted qualitative approach. Qualitative research targets to understand toward understanding the unique nature of human thoughts, behaviour, negotiations and institutions under different sets of historical and environmental circumstances (Benoliel, 1984). Qualitative research design also facilitates gaining of richly detailed understanding of a topic on first-hand experience using a relatively small sample. The design is thus suitable owing to the limited time within which the study was to be conducted and also owing to COVID-19 challenges. Qualitative data is also concerned with depth as opposed to quantity of findings. A qualitative research design is concerned with establishing answers to the whys and how of the phenomenon in question, (djsresearch.co.uk). The qualitative research design will provide direct quotations from the respondents about their experiences, opinions,

feelings obtained from the interviews as well as behaviors, attitudes and actions as recorded from their observations. The method was appropriate to adopt since it allowed convenient data collection with limited resources.

Qualitative research is a form of systematic empirical inquiry into meaning (Shank, 2002). By systematic means the inquiry is planned, ordered and public and following rules agreed upon rules. Empirical means that this type of inquiry is grounded in the world of experience. Inquiry into meaning means researchers try to understand how others make sense of their experience. Denzin and Lincoln (2000) states that qualitative research involves an interpretive and naturalistic approach. The advantages of doing qualitative research include flexibility to follow unexpected ideas during research and explore processes effectively; sensitivity to contextual factors; ability to study symbolic dimensions and social meaning; increased opportunities to develop empirically supported new ideas and theories of more interest to the researcher (Conger, 1998; Bryman et al., 1988; Alvesson, 1996)

3.4 Research Method

This study utilized case study research method which involves a detailed study of the case /subject under inquiry. It typically includes observation and interviews and may involve consulting other people, that is Key informants and personal or public records. Case studies usually have a targeted focus resulting to a thorough description of the subject under review. Nevertheless, it findings are usually generalizable it can be useful in clinical settings and may even challenge existing theories and practices in other domains (Alzheimer .org).

The Case Study for this research was sexually active youth (18-35) in Kianda Ward of Kibera Constituency, Nairobi County, who sought modern contraceptive services at Ushirika Health Centre in the localilty between January and April 2020. The facility runs a

reproductive health program for the Youth. The Program is called Tiko Miles and is funded by the Triggerise Organisation.

The KDHS 2014 established that youth from the slums were more likely to have unintended pregnancies (33percent) than youth from the wealthiest households (10 percent). Poor urban settlement settings are characterized by a myriad of challenges for sexually active youth for example lack of education, lack of finances and lack of exposure to information. This impeded their ability to safeguard their sexual and reproductive health choices and decisions, they therefore find it challenging to negotiate things like whether to have a child, when to have it and how many or how often to have children. The slum dwellings settlements present extreme poverty and poor living conditions exposing young boys and girls to early sexual debut either through sexual violence or by older people taking advantage of them in exchange for money and gifts. Residents of such settings also have limited access to general health services, illiteracy, sexual violence, and lack of access to affordable and quality care, including pre and post birth/delivery services. Urban slums are thus characterized by rampant cases of unwanted pregnancies among the youth.

3.5 Population and sampling

The study was conducted at Ushirika Health Centre in Kianda area, which is one of the wards of Kibra Constituency, Nairobi County. Participants were drawn from sexually active youth who sought modern contraceptive services from the facility between January and April 2020. The target population of this study was all youth who sought modern contraception services at Ushirika Health Centre between the study period of January and April 2020 (100 youth).

The study was conducted within four months. Thus, the sampling frame was the listing of 100 youth who sought contraceptive services from the facility between January and April 2020. This sampling frame was the register of attendance as provided by the facility. From the sampling frame of 100, a sample of 30 youth was selected to participate in the study: 20 youth in two Focus Group Discussions and 10 in for interviews. Four Key Informants were also engaged for the purpose of triangulation.

The study deployed both convenience and purposive sampling techniques. Convenience sampling method entails using respondents that are available at the time of data collection though the respondents have to meet requirements for them to qualify. The sampling technique is appropriate for collecting data at the spur of the moment without rigidity of the procedure (Oso & Onen, 2009). Convenience sampling allow researchers to leverage respondents that can be identified and reached without much struggle/effort. Oftentimes, these normally are individuals that are within the area of study. Through convenience sampling, the facility's Family planning register was used to identify the youth who had sought contraceptive services at the facility within the period the study, then contact and interview those who were available and willing to participate in the interviews.

Purposive sampling, also known as judgmental, selective, or subjective sampling, is a form of non-probability sampling allows researchers to rely on their own judgment when choosing members of the population to participate in their study (Saunders et. al., 2012). Researchers deploying this sampling method always have background knowledge about the purpose and nature of study. With this knowledge the researchers know who best suits to be part of respondents. Researchers use purposive sampling when they want to access

a particular subset of people, as all participants of a study are selected because they fit a particular profile (Wright et al., 2002).

In purposive sampling it upon the researchers' discretion to decide how they are going to constitute a sample, the sample may not necessarily be representative of the study population at hand, however it is targeted in such a manner that the findings are usually generalizable. As the name suggests, researchers go to this community on purpose because they think that these individuals fit the profile of the people that they need to reach (Henry & Garry, 2002). While the findings from purposive sampling do not always have to be statistically representative of the greater population of interest, they are qualitatively generalizable (Teddy et.al., 2007). Purposive sampling was used to select nurses and health administrators for the study because they are the right people to provide the data and information that I require.

3.6 Data Collection Methods

The study applied triangulation, which means using more than one method to collect data on the same topic, triangulation assures complementarity thus, validity of the data collected Triangulation captures different dimensions of the same phenomenon thus enriching qualitative research. Triangulation is preferred in social research as it enabled comparing and combining results thus reducing measurement error. (Prashant, 2013).

The study utilized Qualitative approach and thus applied data collection methods of interviews, key informant interviews and Focus Group Discussions (FGDs) as well as document analysis for better understanding of the relationship between conversations on modern contraceptives among sexually active youth and the adoption of modern

contraceptives in relation to other variables. The approach also facilitated collection of in-depth information.

3.7 Data Collection Instruments

Data collection instruments refer to methods used to collect data from the selected respondents. This study used key informant interviews schedule, Focus Group Discussion Guide and Document review guide.

Four health workers who conduct Family Planning Clinics at Ushirika Health Centre were interviewed for information on Family Planning Services and uptake of the services among the youth in Kianda. The Head, Department of Family Health, Ministry of Health was also interviewed to get information on Government efforts to ensure availability of Reproductive Health Information and services for the youth.

Focus Group Discussions were conducted for the sexually active youth seeking Family Planning/ modern contraceptive services at the facility they facilitated detailed/ broad range of information about personal and group feelings, perceptions and opinions regarding sexually active youth conversations on modern contraceptives, barriers/ inhibitors to use, their preferred sources of information on modern birth control methods and their attitudes towards adoption and use of the commodities. FGDs also offered the opportunity for clarification and provided useful material e.g. quotes that facilitated in-depth understanding of the subject.

The researcher also reviewed documents and contraceptive services videos in the facility's archives to get further information. This complemented the interviews and FGDs and facilitated acquisition of information that I may have missed from the Interviews and

FGDs. The material included Family Planning registers at the facility and recorded videos from previous family planning sessions.

Table 3. 1

Sample selection guide

Data Collection Method	Total Population	FGD	Youth Interviews	KII	Documents Analysis
Youth (Clients)	100	2 FGDs of 10 Clients Each	10 (2 for five days)		
Key Informants (Centre Staff)	20			1administrator 3 nurses	
Documents	Family planning register helped in getting the clients records of attendance and preferred commodities and recorded family planning sessions				Four Registers (From January to December)

3.8 Data Collection and Analysis

With permission from the hospital analysis, I used the facility's family planning registers to identity youth (18-35) who had sought contraceptive services from the facility between January and April 2020. With the help of the administrator and the nurses running the clinics, I then contacted the youth for interviews. The first available 30 formed part of my sample. I conducted two FGDs consisting of 10 youth each, interview 10 individuals and four hospital staff as Key Informants.

Content analysis and Narrative analysis were deployed for data analysis based on the objectives of the study**.** Content analysis is a popular method of analyzing qualitative data among researchers. It is effective/suitable for analyzing documented texts, media and physical items. The study used content analysis to analyze responses from interviewees.

Thematic analysis method was deemed suitable for analyzing content from multiple sources, such as interviews, observations, or surveys. It focuses on using narrations and experiences shared by respondents during interviews or discussions. For this study, content was analyzed based on the study objectives and research questions.

3.9 Data Presentation

The study deployed qualitative research approach and descriptive research design. This approaches use qualitative data collection methods (Gall et.al., 2007). Relevant themes were identified based on research objectives, the themes were then converted into narrative form for further comparison and evaluation.

3.10 Ethical Considerations

The study met the conventional ethical standards by obtaining an introduction letter from the School. The research was also sensitive to informed consent, privacy, confidentiality, and protection of patient/client information. I obtained informed consents from the participants by informing them about the study and giving them the opportunity to ask questions for clarification and allowing them to participate freely.

Privacy of the respondents was protected all through the study. No identifiable information was used in the reporting of the study, for instance using names in the study. Participants were coded using letters or numerals to conceal their identity.

CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Overview

This chapter discusses data analysis and interpretation. It also gives a detailed explanation of the processes, techniques and procedures applied to analyze and present data. Data was drawn from the individual interviews (10 sexually active youth), Focus Group Discussions (two FGDs consisting to ten youth each) and Key Informant Interviews (with 5 Health Workers involved in running Family Planning Clinics) conducted. Recordings of the discussions were used for data analysis and interpretation. Data analysis and interpretation was based on the objectives. Data analysis was through qualitative approach. Qualitative data analysis uses critical descriptions or discussions of the findings. This was intended to generate accurate elaboration of the data for easy understanding for the target persons.

4.2 Modern Contraceptive Conversations among Sexually Active Youth

To find out whether sexually active youth engage in conversations regarding modern contraceptives, respondents were asked several questions for example how long they have been sexually active, whether they have children, whether they talk about modern contraceptives, how long after commencement of a relationship do they start engaging on modern contraceptives, what triggers such conversations, how the partners normally react to this conversations and whether such talks lead to adoption and use of contraceptives.

From the individual interviews and Focus Group Discussions conducted, the study established most respondents had at one point talked about adoption and use of modern contraceptives in their relationships. However, they confessed that these conversations usually come late confirming Kamal (1999) position that spousal /sexual partners'

communication concerning modern forms of contraception, especially in third world countries, happens rarely or is not given the requisite importance.

Participants said that such conversations only take place when a relationship has become stable. Stable for them means when they are already engaging sexually, most of the time after they have already engaged in unprotected sex, in most cases it comes up after an unplanned pregnancy has occurred. For most women, they talked about modern contraceptives to avoid pregnancy, their main reason for talking about modern contraceptives and even adopting them was to prevent pregnancy. The study established that a number of sexually active youth did not think about use of modern contraceptives until unplanned pregnancy had occurred with one of the participants mentioning a four-year-old son with a woman he did not intend to marry giving reasons that when dating, "talks about adoption and use of modern contraceptives were not there." Participant 2 also agreed to this with highlighting that he is currently keen to talk about "adoption and use of modern contraceptives" with the women he date because he does not want to" make the same mistake."

Most men confessed to not initiating conversations regarding modern contraceptives for fear of being mistrusted, i.e. when a man suggests use of modern contraceptive, he is accused of being unfaithful or not being ready for commitment. Participant 3 while expressing his views mentioned that "women normally don't expect a man to initiate a conversation on modern contraceptives" adding that he does not initiate such discussions with the women he dates because "whenever a man does that, he is accused of either being unfaithful or not being ready for a commitment." The participants admitted to staying hopeful that the women would be careful with one of the participant stating "I always pray

that they will be careful enough not to conceive" they had sexual relations. Most men interviewed said they did not find it necessary to engage in conversations about modern contraceptives because they thought it was a lady's responsibility to ensure they do not get unintended pregnancy.

Ladies on the other hand reported to be resorting to emergency methods of contraceptives especially the use of Emergency Pills popularly known to them as P2. The female participants pointed that they found it hard to talk about adoption and use of modern contraceptives because most men are against their use. Participant 2 also agreed to resorting to P2 mentioning that whenever she had sex and felt unsafe she "took P2." Some of the men interviewed said they can only talk about contraceptives or even adopt them when they "are in relationship with a partner that they do not wish to have a long term commitment to" or when they are not sure whether she is the right person to settle down with.

The study also established that youth who had acquired Post-Secondary School Education discuss modern contraceptives more than those who did not go past this level of education. A large number of youth who discussed the adoption were those with college education. Education is therefore a major contributing factor to conversations on the adoption of modern contraceptives among sexually active youth. For those who did not have conversations regarding modern contraceptives; lack of information on contraceptives, myths associated with modern contraceptives, cultural factors and ignorance were the main factors hindering discussion on contraceptives. This supports McCauley et al. (1994) in their preposition that, cultural leaning and religious beliefs, economic status and education level of the women can also affect the selection and use modern contraceptives.

4.3 Sexually Active Youth and Knowledge on Modern Contraceptives

To probe youth knowledge on modern contraceptives, respondents were asked whether they know about types of modern contraceptives, to list the methods they knew and state which ones they preferred. Most of the respondents in the study were familiar with at least two modern methods of contraception and could describe the contraceptives general mechanisms of action. A majority were able to mention at least two of the methods coil, Emergency Pills, Injections (insertion of hormones), Contraceptive Pills and male and female Condoms. The study established that respondents preferred contraceptives in the following order; Condoms, Chip-implant, Pills –E Pills Coil and condoms(combination) Implants and Female condoms. A majority of them had had used at least one type of modern contraceptive. A big number reported to knowing or having used condoms, pills and injections. Participant 1 mentioned that he preferred the condoms since apart from “preventing the woman from becoming pregnant it also protects against sexually Transmitted Diseases and or infections.”

The study established that sexually active youth preferred easy to use contraceptives. Ladies do not like pills that have to be taken consistently or those that have to be taken routinely; they preferred one off methods. One of the participants expressed her preference for P2 or injectable because they are “convenient and do not require to be taken on a daily basis” mentioning that one could easily forget or fail to adhere to the dosage.

4.4 Sources of Information among Sexually Active Youth

The study also sought to establish sources of information on modern contraceptives among sexually active youth. The researcher inquired from participants whether they had heard or seen any messages on modern contraceptives, where they heard or saw the messages. They were also asked whether they recall a particular advert on modern

contraceptives and what made the message memorable. Most respondents said they get information on modern contraceptives from the internet or Social Media Sites, from friends who are health workers and from their peers. A few of them confessed to have gotten information from the mainstream media, Government sites or from health facilities.

The study established that the youth are not comfortable to seek information from elderly health workers or those that are in their parents age brackets for fear of being branded promiscuous. They felt that parents considered it a taboo to talk to their children about contraception because the society teaches against pre-marital sex, as a result whenever you seek information on modern contraceptives from elders they "stigmatize" you and even "brand you wayward or promiscuous." A number of them said they do not prefer information from the mainstream media as mostly it is passed when they are with their parents and the manner in which the messages are delivered makes them uncomfortable. The study further established that sexually active youth most recall messages that creatively designed and ones that incorporate the current trends. A participant in the FGD particularly recalled the advert that demonstrated "condom use using the concept of happy socks" because happy socks were trending at that time.

4.5 Factors that Contribute to or Inhibit Use of Modern Contraceptives

To establish barriers to modern contraceptive access, use and adherence, the study probed respondents' knowledge on where are modern contraceptives accessed/obtained, how easy or difficult is it for sexually active youth to access modern contraceptives, is it easy or hard for the youth to use and adhere to modern contraceptives and why. What are some of the reasons why the youth don't use modern contraceptives? The study established that fear resulting from myths, and misconceptions about modern methods of birth control was the

main reasons why sexually active youth do not adopt and adhere to the commodities. Many of the fears were based on myths and misconceptions this confirms a study by Jeff et. al. (2015) in DRC which established that barriers to using modern FP included lack of knowledge, fear of side effects, religious considerations and sexual partners' opposition to use.

The biggest concern cited by participants was fear that a particular method would lead to them becoming infertile; these fears prevented them from using the products. Many ladies expressed fear that use of pills, implants and injections before getting their first children would lead to infertility. They said they had been advised by family and friends to only start using pills after they have had their first children. A female participant mentioned being advised to only go for the injection only after having the number of children he desired that "it's not good to go before giving birth" because she may not be able to conceive after that. Another expressed warning from her mother against using pills because "they will prevent me from conceiving in future." Other participants also recalled hearing people say that they were using implants and had difficulties conceiving once they removed the implants with "trying to have babies for years" now without success.

Many admitted having little faith in pills, as they were afraid it would affect their ability to have many children. A female participant said that when you use pills, you struggle to conceive and you may not have as many children as you want. Many women in the community discourage girls from using pills because they say it affects you when you want to have children. Others expressed fear that if you are certain form of MC like pills and they backfire; they may give birth to children with abnormalities. Failure to have regular periods or heavy periods which is a side effect associated with some form of modern contraceptives

is interpreted as causing the body to retain 'dirty blood' or losing blood and leading to anemia and stomach pains. Girls were found to fear that when you use certain types of contraception, you retain dirty blood which should come out and this may cause harm. Both male and female respondents linked condoms to discomfort and irritation from the lubricant, they said causes irritation and infections. Male respondent also said condoms reduce sensation hence making sex less enjoyable. They said the feeling is different when you use condoms as opposed to when you don't use. Sex was said to be more pleasurable without condoms.

Modern contraception methods that work by insertion for example coil or implant were feared for having the potential to harm one's internal organs, men also discouraged women from using inserts because they feared it would injure them during intercourse. A female participant admitted that if you tell your man you want to adopt a coil, he will not accept because men say those things injure them when you are having sex. Respondents also said they feared certain modern contraceptives methods because they were rumored as having the ability to cause cancer. Women in the community said that pills are not good as they fill your stomach and cause cancer, they warn us against using them.

Some participants associated pills to loss of appetite and making people thin and heavy bleeding, one of them giving an account of a friend who used an implant a while back and she "could not stop bleeding" so she discontinued the method. Respondents also reported that rumors that modern contraceptives reduce sexual urge by interfering with libido, what they referred to as, making a woman 'cold or turning them into logs' meaning lack of sexual feeling or urge. Some said pills bring a feeling of fatigue, results to mood changes and lack of sexual desire leading to women being accused of being unfaithful to their partners. This

confirms McCauley et al. (1994) position that sexual partner's opposition to the use, fear of side effects, health concerns, and dissatisfaction with sexual sensation when using them have been identified as barriers to adoption of modern contraceptives.

The study established that a majority of the participants were of the opinion that family planning methods interfered with our normal functioning whether pills, implants or injections. Some of the views of the participants were; I have heard people say that they make you cold and reduce the desire to be with your partner (Sexual urge). Your partner will say that you are sleeping with other men. Those injectable are not good as they make you fat and shapeless. I was on pills for six months and I started becoming thin as they made me lose appetite, I stopped using them.

There were also beliefs that modern contraceptives encouraged promiscuity among young women. Both male users and non-users seemed to believe that modern contraceptives were straying. The men interviewed said that only wayward ladies adopt modern contraceptives that they don't like their partners to use them as they encourage women to stray. Respondents also reported that modern contraceptives were associated with unfaithfulness in relationships also a major hindrance to adoption and use. They said that when they suggested using the condoms to their male partners; they were accused of not trusting them. Most of the men said that were not comfortable with the pills as they can lead their women to sleep around with other men because they know they will not get pregnant. Condoms were particularly associated with straying. Most men said you don't need to use condoms if you trust your partner or if you are married unless you are sleeping around.

The participants also cited barrier of access to the services emanating from service providers stating that they find it "difficult to seek information on modern contraceptives"

and even the products if the service providers are elderly or people old enough to be their parents. The challenge identified was that when service providers are in the same category as your parent; "they judge you" instead of giving you information, when you visit them for the services, "they start lecturing you" that you are young and should be focusing on your studies and not engaging in sex.

4.6 Sexually Active Youth Attitudes towards Modern Contraceptives

To examine sexually active youth attitudes towards modern contraceptives, questions of whether the youth should use modern contraceptives, who between the sexual partners should use, who should initiate conversations on modern contraceptives and what were the consequences of not using modern contraceptives were asked. Respondents were also asked whether modern contraceptive services were easily accessible to the youth, whether it was easy to discuss modern contraceptives with their partners, whether modern contraceptives are acceptable in their community.

Majority of the youth knew where to access modern contraceptive services and they agreed that access was not a barrier due to free services in government facilities. One of the major reasons they gave as to why they do not use adopt modern contraceptive was youth unfriendly services. They said they would be more comfortable seeking such services if service providers were their peers as opposed to those who are in their parents' age mates Most respondents said it was not easy to engage their sexual partners in the topic of adoption and use of modern contraceptives. This is because the subject of modern contraceptives just like sexuality and reproductive health has always been treated as a taboo topic by parents and elders in the society.

The study also found that there was a perception that contraceptives are for ladies only. For most men they feared initiating conversations because contraceptive use is viewed as a female thing and any man who brings up the topic in his relationship is viewed as unfaithful, not ready for or not trusting the partner. Most participants believed that since it is the ladies who carry pregnancy, it should be upon them to make sure they prevent a pregnancy when they are not ready for it. One of the male participant mentioned that he did not engage in such conversations because of the "belief that the lady will automatically take necessary precaution" and that "the lady should be the one to take precaution" because she is the one who will bear more responsibilities.

Much as most respondents had knowledge on contraceptives and the benefits thereof; they seem not ready to adopt them owing to the myths and misconceptions surrounding contraceptive use. Most unmarried sexually active youth find it difficult to seek contraceptive services for fear of being branded promiscuous. Some said when they go to pick condoms at service points they are thought to be involved in commercial sex. It was established that the reason why the sexually active youth believed they should use modern contraceptive is to prevent pregnancies more than sexually transmitted infections or diseases. Most respondents therefore did not believe that contraceptive use has benefits to men. A majority did not link contraceptive use to disease prevention. Majority of the participants however believed that the youth should use modern contraceptives specially to prevent pregnancies when they are not ready to have children. However, they seemed not ready to adopt modern contraceptives due to the myths and misconceptions surrounding contraceptive use.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Overview

This Chapter gives a summary of the whole study linking literature review to the background, objectives and findings of the study. It also gives recommendations on what various stakeholders can do to encourage conversations on modern contraceptives among sexually active youth and therefore encourage adoption and use among the youth. It also highlights recommendations for further research.

5.2 Summary

From the Key Informant Interviews, youth interviews and FGDs conducted it was established that a majority of sexually active youth do not discuss modern contraceptives, the few who discuss mostly do it late. It also emerged that not all the discussions or conversations lead to adoption of modern contraceptives. Majority of sexually active youth admitted that they would consider these discussions more and adoption often if there were enough prompts for them i.e. constant information demystifying the myths and encouraging them to adopt and use the commodities. There is therefore need to facilitate trigger conversations on modern contraceptives for effective adoption and adherence.

The study revealed that sexually active youth are fairly knowledgeable on modern methods of birth control because a majority could name at least two and explain the contraceptives mode of action. Modern birth control methods were also associated with waywardness and unfaithfulness in relationships/ marriages. It also emerged that fear of contrary and adverse effects, mostly from what the youth get from the community were a major hindrance to adoption and adherence. The biggest concern was that certain methods of birth control could result to inability to have children. Most hindrances were based on myths

and misconceptions spread in the community. Sexually active youth get information on modern means of birth control from their peers and people they associate with both in the community and in the media and especially social media.

It also emerged that education was a key factor to discussions/ conversations on modern contraceptives. Sexually active youth with post primary school education tended to be more aware and e informed, they also discuss modern contraceptives frequently hence making it easier for them to adopt the products. Those with no education however are less informed and do not discuss adoption of MC and are therefore less likely to adopt MC. Sexually active women with post Primary School qualification proved to be more knowledgeable on the different methods of modern contraception hence it is easier for them to adopt MC as opposed to those with basic education who lacked relevant information on MC and they also tend to be ignorant on family planning matters. The government should put measures to ensure the girl child is educated for future development of the country. Women in the slums should also be educated on modern contraceptives and family planning to encourage adoption and use of MC to control population and ensure accessibility of resources for development. Education of women will also empower them in all spheres of life being economic, social and political.

Most respondents get information on MC from more than one source. Social media were the most preferred source of information on modern contraceptives at. Followed by peers, health care providers and mainstream/ traditional media. This is because social media messages are short creatively designed with short videos, animations or graphics based on the current trends. The fact that traditional media are the least preferred sources means that are not doing enough to educate the masses on modern contraceptives; they should therefore put

measures in place to enhance public education on MC and family planning in general for example incorporating current trends in their messaging to make them popular among sexually active youth.

Most sexually active youth were reluctant to adopt MC until they have families with at least four children owing to the misconceptions that MC can lead to infertility. Slums come up as a result of poverty as most people opt to live in slums because they cannot afford decent housing. Kibera slum is already overcrowded, majority of the residents are unemployed as a result, and they struggle for basic needs. The fact that sexually active youth are still reluctant to adopt MC is therefore worrying and relevant stakeholders should therefore make it a priority to do intensive sensitization on family planning if the vision 2030 and Sustainable Development Goals and other national, regional and global goals are to be realized.

Conversations on MC was highest for youth with college education followed by those with Secondary Education and Primary Education respectively. Education is a major contributing factor to conversations on the adoption modern contraceptives. Education, especially girl child and women should therefore be encouraged to increase awareness and adoption of MC which will lead to family planning and hence development. Conversations and discussions on MC and adoption of MC was higher among Christians as opposed to Muslims. Muslim youth were also reluctant to participate in the FGDs. The Governments and relevant stakeholders should therefore strategically engage religious leaders in order to help break religious barriers and encourage such populations to adopt MC and family planning in general.

A good number of ladies admitted to fearing pregnancy more than Sexually Transmitted Diseases or Sexually Transmitted infections. Those having sexual relations with older men or those who are in relationships with richer partners for financial benefits said it is not usually easy for them to bring up the subject of Modern Contraceptives to their partners so they ended up having unprotected sex. The respondents reported that in such instances they would resort to methods like E-Pills or "safe Days" to prevent conception. In this case again, only girl empowerment can help resolve this problem as such girls mostly engage in sexual relationships for financial gain.

Modern contraceptives should be encouraged as a means to preventing pregnancies and also in the prevention of sexually transmitted infections and diseases. Sexual Reproductive Health lessons should be incorporated into the curriculum early enough so that young girls and boys are knowledgeable enough on contraception matters so that they make informed decisions when they become sexually active. Health Service providers should also ensure that when young people go for other services, they are also sensitized on modern contraceptives.

Youth forums a like WhatsApp and Facebook groups work best in slum areas when one wants pass information to the youth. Relevant stakeholders should utilize such platforms to reach out to sexually active youth with information on modern contraceptives. The Government and partners in the Reproductive Health arena should also revive or intensify placing condoms in private places like public washrooms where the youth can pick them freely. Most respondents said they rarely get information on modern contraceptives from the Government and relevant stakeholders. They admitted that continuous campaigns on both mainstream and alternative media would trigger conversations on modern contraceptives and

facilitate adoption and use among sexually active youth. There is therefore need for continuous campaigns on modern contraceptives targeting sexually active youth in slum settings.

The Government and Reproductive Health Stakeholders should also introduce free sanitary towels donation programs for girls in slum dwellings and reach out to girls with education on modern contraceptives during distribution. Inquiry has established that Youth-friendly family planning services encourages the youth to adopt better Sexual Reproductive Health seeking behaviour. A review of the studies conducted and recent data examining the effects of youth-supportive family planning services on Sexual reproductive health indicators and the factors that encourage or inhibit sexually active youth from accessing family planning services have recommended youth friendly services as a major factor that will contribute to adoption of modern contraceptives among sexually active youth.

The review established factors that can encouraged young people to seek modern contraceptive services. It established that the youth value confidentiality by service providers, specific provider training and ease of access. This reinforces the need for youth friendly services. These findings should be considered when developing, implementing, and evaluating reproductive health services for sexually active youth. Conversations on MC is a major contributing factor towards the adoption of modern contraceptives; relevant stakeholders should therefore give conversations on MC among sexually active youth a priority when formulating family planning policies and also when designing family planning messages. This will help in the adoption of MC, reduce population and improve the quality of life.

5.3 Conclusion of the study

Encouraging and triggering conversations on modern contraceptives among sexually active youth would be effective in enhancing the adoption of MC since it will ease understanding the importance of adoption and address barriers. Adoption of MC among slum will help in birth control in terms of when to have children, the number of children and the spacing. This will help reduce infant and maternal mortalities due to abortions.

This will help increase accessibility to resources and social facilities like schools and hospital. A small population of learned people will mean more employment opportunities; this will help boost economic growth and reduce crime rate hence development. A healthy population will also ensure productivity which will also boast economic growth hence development. Factors such as spousal communication, education, religion and sources of information should be considered by stakeholders when designing policies and family planning messages.

5.4 Recommendations of the Study

Conversations among sexually active youth regarding adoption of Modern Contraceptive is a novel area that needs more research to establish how best to normalize the conversations and help the youth make informed decisions regarding Family Planning. It also emerged that youth are more concerned about preventing pregnancies more than Sexually Transmitted Infections and Diseases. This is an area of concern given the rise of HIV infections among the youth.

Further research should be done to device ways of encouraging youth to adopt modern contraceptives as means of preventing unintended pregnancies and STIs/STDs. Myths and misconceptions by communities regarding modern contraceptives was a major

barrier to adoption and sustained use of the products, more research needs to be done, utilizing the Theory of Social Constructivism to address this barrier.

REFERENCES

African Population and Health Research Centre (2002). *Population and health dynamics in Nairobi informal settlements*. Nairobi: African Population and Health Research Centre

Agha S. (2010). Intentions to use contraceptives in Pakistan: Implications for behavior change campaigns. *BMC Public Health*.; 10:450.

Alena D-G, Nancy L, Salome W. (2011) Dimensions of poverty and inconsistent condom use among youth in urban Kenya. AIDS Care.; 23(10):1282–90.

Balaiah et al., (2005): Determinants of spacing contraceptive use among sexual partners in Mumbai: A male perspective. *J Biosoc*

Bankole A, Singh S. United States: Alan Guttmacher Institute (2007). Women with an unmet need for contraception in developing countries and their reasons for not using a method.

Becker S, (1996). Sexual partners and reproductive health: *A review of couple studies. Studies in family planning*.

Blanc AK et al. (1996). *Negotiating Reproductive Outcomes in Uganda*, Calverton, MD, USA: Macro International and Uganda Institute of Statistics and Applied Economics

Bongaarts J, Bruce J. (1995). The causes of unmet need for contraception and the social content of services. Stud Fam Plann. 26:57–75.

Burke Holly MC, Ambasa-Shisanya C. 2011; Qualitative study of reasons for discontinuation of injectable contraceptives among users and salient reference groups in Kenya. Afr J Reprod Health. 15(2):67–78.

Charles N. 2004; Unwanted Pregnancy and Sexually Transmitted Infection among Young women in Rural Kenya. *Cult Health Sex* 6(1):31–44.

Chandra A, Martinez GM, Mosher WD, Abma JC, Jones J. 2005. Fertility, family planning, and reproductive health of US women: Data from the 2002 National Survey of Family Growth. *Vital and health statistics*. Series 23 Vol. 25. Maryland, USA:

Daniel EE, Masilamani R, Rahman M. (2005). The effect of community-based reproductive health communication interventions on contraceptive use among young married sexual partners in Bihar, India. *Int Fam Plan Perspect*.

DeRose L. F, Dodoo F. N, Ezeh AC, Owuor T. O. (2004). Does discussion of family planning improve knowledge of partner's attitude toward contraceptives? *Int Fam Plan Perspect,* 30(2):87-93.

Ezeh A, Mberu B, Jacques E. 2009; Stall in fertility decline in Eastern African countries: regional analysis of patterns, determinants and implications. *Biol Sci.* 364(1532):2991–3007

Factors Associated with Contraceptive Use among Jordanian Muslim Women: Implications for Health and Social Policy 2013; *J Int Womens Stud.* 12:168–84.

Fathizadeh N, Salemi P, Ehsanpour S. 2011; Dissatisfaction with contraceptive methods. *Iran J Nurs Midwifery Res.* 16:79–82.

Fishbein, M. & Ajzen, I. (1975). Belief, attitude, intention, and behavior: An introduction to theory and research. Reading, MA: Addison-Wesley.

World Health Organization, (2011). Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008 Geneva: World Health Organization.

World Health Organization, (1998). Unsafe Abortion: Global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data. Geneva: World Health Organization.

Hans-Peter K, Jere BR, Susan WC. . 2001; The density of social networks and fertility decision: Evidence from South Nyanza District, Kenya. *Demography.* 38(1):43–58.

Ikamari et al. (2013) Pregnancy and Childbirth. *BMC* 13:69 Page 2 of 9 http://www.biomedcentral.com/1471-2393/13/6

Izugbara Chimaraoke O, Ochako R, Izugbara C. (2011). Gender scripts and unwanted pregnancy among urban Kenyan women. *Cult Health Sex*. 13 (9):1031–45.

Izugbara CO, Ochako R, Izugbara C. (2011), Gender scripts and unwanted pregnancy among urban Kenyan women. *Cult Health Sex.* 13(9):1031–1045.22.

Jere B. R, Hans-Peter K, Susan W. C. (2002). Social networks and changes in contraceptive use over time: Evidence from a longitudinal study in rural Kenya. Demography. 39 (4):713–38.

Kabiru Caroline W, Orpinas P. (2009). Correlates of Condom Use Among Male High School Students in Nairobi, Kenya. *J Sch Health.* 79:425–32.

Kamal SMM. (2014). Interspousal Communication on Family Planning and Its Effect on Kenya Demographic and Health Survey (KDHS)

Ministry of Health (2015). Kenya National Family Planning Guidelines for Service Providers (6th Edition)

Kenya National Bureau of Statistics (KNBS), ICF Macro. Kenya Demographic and Health Survey 2008–09. Calverton, Maryland: KNBS and ICF Macro; 2009.

Kenya: More Education Equals Less Teen Pregnancy and HIV. Integrated Regional Information Networks: 2008, accessed on April 9, 2014.

Klomegah R (2006.) Spousal communication, power, and contraceptive use in Burkina Faso, West Africa. *Marriage Fam Rev*

Link C. F. (2011). Spousal Communication and Contraceptive Use in Rural Nepal: An Event History Analysis. *Stud Fam Plann.* 42:83–92.

Mahmood N, Ringheim K. (1996). Factors affecting contraceptive use in Pakistan. *The Pak Dev Rev.* 35:1–22.

McCauley A. P, Robey B, Blanc A. K, Geller J. S. (1994). *Opportunities for women through reproductive choice.* Washington, DC.

Michellea D, Robb S., Marcie R., Doris B., (2012). The influence of perceptions of community norms on current contraceptive use among men and women in Ethiopia and Kenya. *Health Place.* 18:766–73.

Mon MM, Liabsuetrakul T. (2010). Predictors of contraceptive use among married youths and their husbands in a rural area of Myanmar. *Asia Pac J Public Health*. 24:151–60.

Gharaibeh MK, Oweis A, Shakhatreh F, Froelicher ES., Mott F L, Mott S. (1985). Household Fertility Decisions in West Africa: A Comparison of Male and Female Survey Results. *Stud Fam Plan*116:88-99.

Mosha I, Ruben R, Kakoko D. (2013). Family planning decisions, perceptions and gender dynamics among couples in Mwanza, Tanzania: a qualitative study. *BMC Public Health.* 13:523

Nagase T, Kunii O, Wakai S, Khaleel A. (2003). Obstacles to modern contraceptive use among married women in southern urban Maldives. *Contraception.* 68:125–34.

Naomi R, Susan W. (1997). The Buzz Outside the Clinics: Conversations and Contraception in Nyanza Province, Kenya. *Stud Fam Plann.* 28(4):290–307.

National Council for Population and Development (2013). Kenya Population Situation Analysis. In: NCPD and UNFPA.

New York: 2004. United Nations Population Fund. State of the world population. The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty.

Njoroge Kezia M, Olsson P, Pertet AM, Ahlberg BM. (2010). Voices unheard: Youth and sexuality in the wake of HIV prevention in Kenya. *Sex Reprod Healthc.* 1(4):143–8. doi: 10.1016/j.srhc.2010.07.006.

Okanlawon K, Reeves M, Opeyem AF. (2010). Contraceptive Use: Knowledge, Perceptions and Attitudes of Refugee Youths in Oru Refugee Camp, Nigeria. *Afr J Reprod Health*. 14(4):17–26.

Oyedokun, Amos O. (2007): Determinants of Contraceptive Usage. *Journal of Humanities & Social Sciences,* Volume 1, Issue 2.

Population Reference Bureau, (2008). *Family Planning Worldwide*, Data sheet.

Remare E, Catherine K. (2012). Physical access to health facilities and contraceptive use in Kenya: Evidence from the 2008–2009 Kenya Demographic and Health Survey. *Afr J Reprod Health*. 16(3):47–55.

Rodríguez I, Say L, Temmerman M. (2014). Family planning versus contraception: what's in a name? *The Lancet Global Health*; 2(3): e131–2. doi:10.1016/S2214-109X (13)70177-3.

Ross John A, Agwanda Alfred T. (2012). Increased Use of Injectable Contraception in Sub-Saharan Africa. *Afr J Reprod Health*. 16(4):68–80.

Rozina M, Uzma A, Haleema HA. (2008). Contraceptive Knowledge, Attitude and Practice Among Rural Women. *J Coll Physicians Surg Pak.* 18(9):542–5.

Salem RM, Bernstein J, Sullivan TM, Lande R. (2008). *Communication for Better Health Pop Rep*

Samandari et al.,2010: The role of social support and parity on contraceptive use in Cambodia. Int Perspect Sex Reprod Health.;36:122–31.

Sathar ZA, Chidambaram VC. Netherlands: Voorburg; 1984. Differentials in contraceptive use.

Schenker JG, Rabenou V. (1993). Family planning: Cultural and religious perspectives. *Hum Reprod.* 8:969

Singh S. (2006). Hospital admissions resulting from unsafe abortion: Estimates from 13 developing countries. *Lancet.*;368:1887–92.

Stephenson, R., Baschieri,S, Clemens,S., Hennik,M and Madise,N. (2007)

https://www.djsresearch.co.uk/glossary/item/Qualitative-Research-Design–76.

Tavrow P, Karei Eunice M, Obbuyi A, Omollo V. (2012). Community Norms About Youth Condom Use in Western Kenya: Is Transition Occurring? *Afr J Reprod Health*.;16(2):241–52.

Terefe A, Larson CP. Modern contraception use in Ethiopia: Does involving husbands make a difference? *Am J Public Health.* 1993; 83:1567–71.

Tones,K and Green,J (2004) Health promotion: planning and strategies: Sage,London. 6th ed.

United Nations Population Fund (1994). Program of action of the international conference on population and development.

USAID (2009). Achieving EQUITY for the Poor in Kenya: Understanding the Level of Inequalities and Barriers to Family Planning Services. Kenya: USAID

Wafula S, Obare F, Bellows B. (2014). Evaluating the Impact of Promoting Long Acting and Permanent Methods of Contraceptives on Utilization: Results from a Quasi Experimental Study in Kenya. In: *Population Association of America*.2002;2:1.

Wambui T, Eka A-C, Alehagen S. (2009). Perceptions of family planning among low-Income men in Western Kenya. *Int Nurs Rev*.; 56:340–5.

Wang CC, et (1998) Reducing pregnancy and induced abortion rates in China: Family planning with husband participation. *Am J Public Health*.

World Health Organisation (2011). *Making Pregnancy Safer: Annual Report 2007* Geneva. 2008; 11:7.

Wu L (2010). A survey on the knowledge, attitude, and behaviour regarding contraception use among pregnant teenagers in Beijing, China. *Clin Nurs Res*.; 19:403–15. 27.

Sedgh G, Hussain R, Shaikh T, Babar (2010). Unmet need for family planning in Pakistan – PDHS 2006–2007: it's time to re-examine déjà vu. *Open Access Journal of Contraception*; 1:113–8.

United Nations Population Fund (2004). Country Profile for Population and Reproductive Health: Policy Developments and Indicators.

APPENDICES

Appendix A: Consent Form

I ……………………………………………………………….. hereby willingly to participate in the study on modern contraceptive conversations among sexually active youth. I have been made aware that information I give will treated with confidentiality and only accessible to the researcher for purpose of data analysis and presentation. I am also duly informed that my name will not be linked to the information I give that coded identification for the purpose of recording the responses and capturing all the aspects of the discussion and that my information will be treated with utmost confidentiality.

I have also been duly informed that my participation in the interview is by my own will and that I pull out of the interview at any point and will not be penalized for my decision to do so. I will also provide my contacts to enable the researcher follow up with further questions and information should there be need. I am also assured that my contacts will be treated with confidentiality and will not linked to the information I give.

Signed: …………………………………… Date: ……………………………

Appendix B: Introduction to Interviews and Focus Group Discussion (FGD)

My name is Elizabeth Ochanda. I am a student at the University of Nairobi. I am conducting a study on analysis of family planning conversations among sexually active youth in Kianda Ward, Kibra Constituency, Nairobi. This is a project undertaken in partial fulfilment of requirements for the degree of Master of Arts in Communications Studies. The study can also be useful for informing the programs and policy makers implementing Family Planning to design programs that respond to the needs of the youth. All of the information that you provide will be kept confidential and only accessible to me for the purpose of data analysis and presentation.

Your names will not be linked to the information you give however for purposes of recording all your responses we shall use coded identification. I will be recording your responses to enable me capture all the aspects of the discussion and will endeavour to maintain confidentiality for all our responses.

Please note that your participation in the survey is voluntary but I will however appreciate your responses and contributions. You are free to stop responding to the questions at any point and will not be penalized for your decision to do so. I will also be seeking your contacts in order to follow up with further questions and information should there be need. I will keep your contact information confidential and will ensure it is not linked to the information you give me. If you are willing to participate in the study please sign a consent form (To be provided separately) if you have questions or concerns before or during the discussion, please feel free to ask. Also do not hesitate to contact me should you have a question later on after the discussion. (My contact is provided on the consent form).

Appendix C: Focus Group Discussion (FGD) Guide

i. Do you know of any modern contraceptive methods? Please list them. Probe knowledge on modern contraceptives.
ii. Who should use Modern Contraceptives and why? Probe knowledge and understanding of modern contraceptives in regards on attitudes on who should use them.
iii. What are the barriers to modern contraceptive access, use and adherence? Probe knowledge and perception of barriers for modern contraceptives use with particular interest in;
iv. Where are modern contraceptives accessed/obtained?
v. How easy or difficult is it for sexually active youth to access modern contraceptives
vi. Is it easy or hard for the youth to use and adhere to modern contraceptives? Why?
vii. What are some of the reasons why the youth don't use modern contraceptives?
viii. Should the youth use modern contraceptives If yes, why and if no, why not
ix. Role of Public Awareness Campaigns for promoting modern contraceptive use
x. Have you heard of any modern contraceptive awareness campaign?
xi. Which ones have you heard of?
xii. Where did you hear about them? Probe sources of information on modern contraceptives
xiii. Do you think awareness on Modern contraceptives reaches the youth?
xiv. Do you think having Awareness campaigns is helpful for promoting adoption of modern contraceptives use? How?
xv. Understanding usage patterns of modern contraceptives among sexually active youth.
xvi. How does use or non-use of modern contraceptives affect the youth.
xvii. What are some of the challenges that the youth may face in the uptake and use of modern contraceptives (Probe for adoption, Adherence, attitudes, access gaps)
xviii. What kinds of concerns do the youth have about modern contraceptives and their use?
xix. What forms of support should the youth be given or provided so as to access modern contraceptives? Where and from whom?
xx. For those using modern contraceptives, what are your views about the services provided by the healthcare professionals when accessing the commodities?
xxi. Do you discuss adoption of modern contraceptives with your partner? If no, Why?
xxii. What exactly do you discuss about modern contraceptives
xxiii. If yes does the discuss affect adoption and use of modern contraceptives?
xxiv. Just before we finish, do you have any questions for me?
xxv. Is there anything you had wanted to say but didn't have the chance to say?

Appendix C: Key Informant Interview Guide

i. Tell me about yourself and how long you've been with the facility
ii. Do you work closely with youth 18-35 years?
iii. What services do you provide?
iv. Have you worked in any other area of the organization?
v. Knowledge on Modern contraceptives among the youth
vi. In your opinion are youth knowledgeable about Modern Contraceptives
vii. Are the youth interested in information on modern contraceptives?
viii. In your opinion where do the youth access information and knowledge on Modern Contraceptives?
ix. What is their most preferred source?
x. Why do they prefer this source of information?
xi. What is their preferred source of contraceptive services?
xii. Are you aware of the National Family Planning Guidelines?
xiii. Tell me a little bit about what you know
xiv. In your opinion does the guideline address contraceptive needs for the youth?
xv. How do you pass information regarding your family planning services for the youth?
xvi. Are you involved in the facilities Family Planning campaign? (Including design, implementation and monitoring? If yes, what is your role?
xvii. From your experience, are sexually active youth using modern contraceptives?
xviii. Where do the youth access modern contraceptives from?
xix. What kinds of concerns do the youth have about adoption and use of modern contraceptives?
xx. What are some of the support needs for to adopt and sustainably use modern contraceptives?
xxi. What are some of the barriers that they face in accessing, using and adhering to modern contraceptives?
xxii. In your opinion, are public awareness campaigns useful for influencing adoption of modern contraceptives among the youth?
xxiii. What are the campaign/s that have worked so far to influence adoption of modern contraceptives among the youth?
xxiv. What is so unique about the campaign/s identified above?
xxv. In your opinion who should run these public awareness campaigns?
xxvi. What are the media that are most appreciated by young women to get information on modern contraceptives?

Appendix D: Youth Interview Guide

i. How long have you been sexually active?
ii. Do you have children?
iii. How often do you discuss on adopting and use of modern contraceptives with your partner?
iv. Is the information from the source adequate to enable you make decisions concerning modern contraceptives?
v. What form of modern contraceptive do you use?
vi. Which modern forms of contraceptives are you familiar with?
vii. How soon after your marriage/relationship did you adopt the use of modern contraceptives?
viii. Did your partner object the idea of modern contraceptives? If yes, what reasons did he/she give for being against the adoption of modern contraceptives?

Appendix E: Interview and FDG Guide for Health Officials

Interview Guide

i. What age bracket do most of your clients seeking contraceptive services fall into
ii. What type of contraceptives does the facility stock?
iii. As per your experience, what are the reasons that push the youth to seek contraceptives?
iv. Do you charge for contraceptive services?
v. Which are the most preferred?
vi. How do clients get to know about your Family Planning services?
vii. Do you charge for contraceptive services?
viii. What do you think are barriers to sexual partners adopting modern contraceptives?

Focus Group Guide

i. Do you think sexually active youth discuss modern contraceptive with their partners?
ii. Where do the youth get information concerning modern contraceptive?
iii. Do you think the information from the source/s adequate give adequate information to enable youth make decisions concerning modern contraceptives?
iv. What form of modern contraceptives are popular among the youth?
v. Why is the contraceptive preferred by the youth?
vi. Which other modern forms of contraceptives are you familiar with?
vii. How soon after your marriage/relationship did you adopt the use of modern contraceptives?
viii. Did your partner object the idea of modern contraceptives? If yes, what reasons did he/she give for being against the adoption of modern contraceptives?