BARRIERS FACED BY YOUNG ADULT FEMALES IN ACCESSING MODERN CONTRACEPTIVE METHODS IN MUKURU KWA NJENGA SLUMS, NAIROBI CITY COUNTY

FAITH ANYANGO OSORE

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DECLARATION

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

Signature_____ Date_____

Faith Anyango Osore

Registration number: N69/77220/2015

This project has been submitted for examination with my approval to the University supervisor.

Signature_____ Date_____

Dr. Dalmas Omia

DEDICATION

This project is dedicated to my family, friends and colleagues for their enormous support.

ACKNOWLEDGEMENT

I acknowledge my supervisor for his guidance and constructive criticism, which was central to the development and completion of the project. To the entire group which participated in providing the required information for the study. To almighty god for giving me good health.

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LIST OF ABBREVIATIONS AND ACRONYMS

AACSE	Age Appropriate Comprehensive Sexuality Education
APHRC	African Population and Health Research Center
CPR	Contraceptive Prevalence Rate
DHS	Demographic Health Survey
FP	Family Planning
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome
ICF	International Classification of Functioning
IEBC	Independent Electoral Boundaries Commission
IUD	Intrauterine Device
KNBS	Kenya National Bureau of Statistics
MLE	Monitoring Learning & Evaluation
NASCOP	National AIDS and STI Control Program
SDGs	Sustainable Development Goals
STIs	Sexually transmitted infections
TPB	Theory of planned behavior
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health organization

ABSTRACT

This study was cross-sectional, descriptive with qualitative and quantitative outlook. Guided by the Theory of Reasoned Action, the study focused on the barriers that young adult women face in accessing modern contraceptive methods in Mukuru kwa Njenga informal settlement, Nairobi County. Data collection involved using survey, case narratives and Key Informant interviews and the sample consisted of 100 women aged between 19 and 24 years. Data analysis employed quantitative and qualitative techniques. Data from case narratives and Key informant interviews was transcribed verbatim and subjected to content analysis to extract key themes. Statistic Package for Social Sciences software version 21 was used to analyze quantitative data after coding and cleaning and data was presented using figures and charts. The findings show that although the young adult women are sexually active, they face barriers in accessing and utilizing modern contraceptive methods. These barriers are of social and economic foundation. Myths and misconceptions on contraceptive methods, religious beliefs, gender relations/power and decision-making as well as competing financial needs pose barriers in accessing modern contraceptive methods for young women. Resultantly, there is either low or inconsistent access and utilization of modern contraceptive methods and this would account for the rising cases of unintended pregnancies among young adult women and consequently the rising demand for abortion. The study concludes that the consequences of low contraceptive use among sexually active women can be countered by addressing the underlying barriers. Due to social and economic barriers, women opt to forego contraception and this runs against family planning and population control best practices. The study recommends that it is important to educate young adults and create awareness among them in regard to the importance of contraception and availability of services. With education and sensitization, they can make informed decisions on accessing and using modern ways of contraceptive. It is also recommended that the authorities focus on educating the women/girls as a pathway towards economic independence. This will tackle the problem of low contraceptive use due to low income.

CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Family planning means the use of contraceptives or other steps that intimate partners use to plan for the number and spacing (birth interval) of children they wish to sire (Okal *et al*., 2016). There are various forms of contraceptives such as sterilization, abortion, contraception and employing other natural methods to prevent pregnancy. The decision helps married couples to get the desired number of children and also space in between the children. Majority of urban male and female young adult residents in Kenya live in poor informal settlements often referred to as slums (African Population and Health Research Center, 2014). Further, there are unique vulnerabilities that the adult male and female population living in these slums face (The National Adolescent Sexual and Reproductive Health Policy, 2015). For instance, they are likely to engage in sexual activities when they are still young, sexual harassment, engaging in prostitution and early or unprotected sex.

Magnani *et al* (2001) indicate that there are barriers to obtaining contraceptive methods even in the context of loose legal control because healthcare providers in developing countries do not offer unmarried young adult female modern contraception information and services. The reason for such is because they are against the premarital sexual activity. On the other hand, young adults have financial constraints, consistently use contraceptives and in cases they get help, it is only limited to condoms (Wulifan, Jahn and De Allegri, 2016).

There is also a common belief that long-acting hormonal contraceptives and intrauterine devices are not good for nulliparous women thus becoming a barrier to contraceptive use among young adults. The term modern contraceptive is as a product or medical procedure that interferes with sexual reproduction cycles (Okal, *et al*. 2016). Indicators of modern contraceptive include number of unintended pregnancies, government expenditure of family planning, and contraceptive prevalence rate.

Traditional methods of family planning are understood as birth control methods which rely on the beliefs, practice or customs which are passed down from generation to generation with an aim of preventing pregnancy (Kennedy & Creati, 2011). The difference between modern and traditional includes the existence of medicine in modern family planning to control the birth outcomes.

Globally, the Asian women use of modern contraception is averagely rated at 42.8%. This is due to various social and economic barriers, traditional contraceptive methods, cultural attitudes, and knowledge regarding methods and reproduction (Rahman, Hanafiah & Manaf, 2013). Further, the poor utilization of contraceptive practices amongst Asian Women is mainly due to social barriers (Singh & Darroch, 2012). According to Tsui (2016), in sub-Saharan Africa, there are myriad obstacles encountered by women in relation to the contemporary contraception as a result of factors such as lack of information, inability to take family decisions on their own, stereotypes about contraceptives, cultural believes and inaccessibility health facilities and poverty.

Okech, Wawire & Mburu, (2011) explains that in Kenya, repeated accounts indicate that many young adult women rely on information from peers rather than health professionals. Young people's misconceptions also act as a significant barrier to modern contraceptive use. Examples of these misconceptions are that family planning is for married women only, side effects and it is against religion. Okech, Wawire & Mburu, (2011) are of the view that the key factor for interruption of contraceptive use for most women is the associated side effects. At the same time inadequate knowledge on modern methods of contraception and associated effects account significantly for the reduced utilization. This then shows a gap particularly to the vulnerable 19-24-year-old young adult females who have not been researched.

Therefore, there is need for concerted efforts and actions by the government and relevant bodies to take action on the economic and health challenges of contraceptives on the population of people living in the slums or the ones living in urban but are faced with poverty. This is important to help achieve Sustainable Development Goals (SDGs) 4, 5 and 7. These goals relate to quality education, gender equality, and access to clean energy.

1.2 Problem Statement

The Kenya Demographic Health Survey (KNBS, 2014) shows that although women in reproductive age do not use contraceptive methods, they are avoiding pregancy. Reasons for such includes lack access to modern contraceptive commodities of which this accounts for a vast majority of unplanned pregnancies (KNBS, 2014). Studies in Kenya

around contraception have focused on various demographic categories including age and gender. The study for example by Wairagu (2013) did not isolate young adult females aged between 15 and 24 in the contraception use experiences in informal settlements.

On the other hand, Toshiko Kaneda (2013) highlighted various reasons for unmet family needs in Kenya with emphasis on factors such fear of side effects and health concerns, opposition husband, religious beliefs; the reason is having sex infrequently without the use of any contraception methods. Ochako *et al*., (2016) study on barriers to modern contraceptive focused on rural areas in three regions namely Nyanza, Coast, and Central regions. The study looked at socioeconomic factors affecting women from different regions in Kenya. Further, it focused on barriers such as myths, knowledge, and experience, fear of side effects and how the use of contraceptives is associated with promiscuity. In addition, the Kenya National Adolescent and Youth Survey Report (2015) reckons that parents have been negligent and have failed to give appropriate guidance and counselling to young female adults.

There is a 27% gap particularly in accessing modern contraceptives especially to young adult female and male because it is estimated that only 10% of public health facilities are youth friendly implying that there are so many young people in need of sexual reproductive health services and are unable to seek such services due to fear of being judged (Service Availability and Readiness Assessment Mapping Report, 2013). Therefore, this study will look into the barriers faced by young adult females in accessing

modern contraceptive methods in Mukuru kwa Njenga slum, in Nairobi. The study wished to answer these research questions;

i. What are the social barriers faced by young adult females in accessing modern contraceptive methods in Mukuru Kwa Njenga slums, Nairobi County?
ii. What are the economic barriers faced by young adult women in accessing modern contraceptive methods in Mukuru Kwa Njenga slums, Nairobi County?

1.3 Study Objectives

1.3.1 Overall Objective

The main objective was to assess barriers faced by young adult females in accessing modern contraceptive methods in Mukuru kwa Njenga slums, Nairobi City County.

1.3.2 Specific Objectives

i. To establish social barriers faced by young adult females in accessing modern contraceptives in Mukuru Kwa Njenga slums, Nairobi County.
ii. To determine economic barriers faced by among young adult females in accessing modern contraceptives Mukuru Kwa Njenga slums, Nairobi County.

1.4 Assumptions of the study

i. There are social barriers to modern contraception faced by young adult females in Mukuru Kwa Njenga slum, Nairobi City County.
ii. There are economic barriers to modern contraception faced by young adult females in Mukuru Kwa Njenga slum, Nairobi City County.

1.5 Justification of the Study

Despite the increased awareness on the use of modern FP, this is an indication that young women face various barriers in meeting their sexual reproductive health. A logical understanding of numerous obstacles and the target respondent's characteristics with the need for family spacing in Mukuru Kwa Njenga slum is essential for Kenya's population policy and monitoring of household planning program. Mukuru Kwa Njenga slum is one of the highly populated slums, with an estimated population of 700,000 people, with a poverty level of above 70% (KNBS, 2010).

The study is substantial in many ways concerning potential contribution to the policy on sexual reproductive health among the adolescents. This includes initiation of programs such as Age Appropriate Comprehensive Sexuality Education (AACSE) in Secondary Schools and strengthening of developmental programs in the country. The study also takes into account prevalent socio-economic circumstances in design of the message based on the barriers faced by young adult females in accessing modern contraceptives, consistent supply of modern contraceptives in health facilities within Counties in Kenya to reach the unique age group of 19-24 years.

This study also helps the government to accelerate the uptake of modern contraceptive methods in informal settlements in Nairobi. In addition, the study informs the government and other stakeholders to initiate youth friendly programs to create awareness and disregard misinformation on myths related to the acceptance of contemporary methods of contraceptive. Finally, it contributes to the academic field by

providing the relevant information and ensures that sexual reproductive health services are delivered in a way that addresses particular needs and does not discriminate against any one and also ensures privacy and secrecy that promotes human dignity for the young adults.

1.6 Scope and study Limitations

The study targeted the young female adults in Kenyan urban informal settlements in Mukuru Kwa Njenga Slum, in Nairobi and not any other slum in Nairobi. The study targeted respondents comprising of young adults aged between 19-24 years. The study did not collect information from women below 19 and above 24 years. On the other hand, the findings were generalized to other informal settlements in Nairobi such as Kibera, Korogocho, Mathare, and other informal areas due to their similarity particularly when the general population of this study is concerned. This being a sensitive study some of the respondents were unwilling to talk about modern contraceptive methods. However, the researcher established a rapport with the respondents to assure them of them of their confidentiality and anonymity.

1.7 Definition of key terms

Barriers: A circumstance or obstacle that keeps people apart from making any communication or progress in a particular area.

Family Planning – this is a programme where couples and individuals come up with strategies and measures relating to the number of children they are going to have and how they will space them. It includes the information and the means they use to implement the programme and having access to varieties of modern methods of contraceptives which are safe and effective.

Modern contraceptive: This is a contemporary product or medical process that inhibits a woman from getting pregnant after sexual intercourse.

Unmet family planning needs – are the women who desire to use contraceptives but lack the means, access or the information on how/where to get the contraceptives

Women of reproductive age – is referring to those women of particular age who are in family planning.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The literature review presents the unmet Family planning needs. The review has been carried out along the following sub-headings: overview of unmet family planning needs, conceptualization of family planning in Kenya, factors influencing family planning option, social and economic factors affecting modern contraceptives in Kenya, theoretical and conceptual framework explaining the study variables. The section concludes by discussing a theoretical and describing a conceptual framework that will guide the study.

2.2 Conceptualization of Family planning

In Kenya, the trend of family planning utilization amongst women aged between 15 and 24 years has gradually been increasing from 7% in 1978 to 46% in 2008 and 58% in 2014 and it also increases as the young adult females get to the age of 19-24. This has resulted to decline in fertility rate over the years from 8.1 births per woman in 1977/8 to 4.7 in 1998, 4.9 in 2003 and 4.6 in 2008 and 3.9 in 2014 (KNBS, 2014). However, this fertility rate is still high in a developing country. The contraceptive methods available in Kenya include male or female sterilization, oral pills, and intrauterine device, injections, and implant, male and female condoms. Methods such as withdrawal and rhythm method constitute the traditional contraception (Assefa & Fikrewold, 2011).

The use of intrauterine device has slowly diminished from the Kenyan contraceptive market for the last 15 years though it is one of the methods that has proved to be safe, effective and widely acceptable coupled with its low cost (Assefa and Fikrewold, 2011). The proportion of women using this method has dwindled and fallen to 31-15% between 1984 and 2008-9 despite the fact that women using other modern methods have increased drastically to three times the earlier figure in the same period. However there are still a substantial number of women whose needs for contraceptives is still unmet and the number has increased over the years as many women enter their reproductive ages. This is also attributed to the lack of adequate donor funds and a mixture of both short and long term factors which are mostly external, (Wubegzier and Alemayehu, 2011).

The contemporary methods of contraception has increased drastically as more women get educated. It has been shown that more than half of educated women in marriages use modern methods of contraception than the 8% who are illiterate (KNBS, 2003). The use of contraceptive has increased only marginally since 1998 form 39% to 41% among married women in 2008. This is an indication of the slower uptake of family contraceptive among women. However, from 2008 to 2014 the family planning coverage in Kenya stands at 74% which shows high uptake as compared to previous years (Ezeh, Kodzi & Emina, 2010).

2.3 Overview of unmet family planning needs

A number of studies have revealed how women in informal settlements have inadequate contraceptive services to meet desired reproductive health care (Wulifan, Jahn and De

Allegri, 2016). Many of them acknowledged to lack of sufficient knowledge to deal with these issues when they occur in the neighborhood. In most of the developing countries, many couples who are sexually active prefer not to get pregnant. At the same time, they do not use any contraceptive methods to prevent getting pregnant and there they are the one who grouped under the unmet needs for family planning (Biddlecom and Kantorova, 2013).

Bongaarts (2014) opines that despite concerted efforts designed to enhance access and utilization of various modern methods of contraception among women in developing countries, the total met need has hardly changed over time. However, there is a huge variation across the regions concerning total unmet need. Nevertheless, these regional determinants variables in various regions are more or less similar. Further, several groups of women are within the group of the unfulfilled need for contraception. Some are of young aged, middle and older age, of different education backgrounds, and others have more than one living children. Besides, there are those with little knowledge of modern contraceptives and different wealth quintiles.

The idea of those women whose needs for family planning are still unmet in developing countries is essential for categorizing women of reproductive age into: those who might wish to use, those who are presently using them, the contraception method that has been found to be the best and how to address the family planning unmet need (Biddlecom and Kantorova, 2013). He further recommends that policymakers should be directed toward unmet family planning needs because it leads to unintended pregnancies, which in turn

pose risks for women in general. In Africa and other developing countries in Asia, about 25% of pregnancies are unplanned which means they are unwanted or mistimed (Bongaarts, 2014).

Unwanted pregnancies and births pose significant risks for children's health and their wellbeing. Documented studies from the journal of reproductive health, according to Bongaarts, (2015) unmet family planning contributes to rapid population growth in developing countries. In general, unmet need for FP has had huge impacts on the total fertility rate. Therefore, if countries, especially in Africa, have the capability to eliminate the unmet need, then women fertility rate would substantially reduce. Decreasing the scale of unmet family need reduces maternal mortality and morbidity. In addition, it can be seen as an avenue of guaranteeing women's rights by making sure that they can choose the number of children they wish, when to get pregnant and other issues (Brenner, et al., 2016).

Bongaarts (2014) explains that lack of sufficient reproductive health services for women of reproductive age more particularly young females comprises has been attributed the high number of women with unmet need for contraceptive. Therefore, such prevalence gives a clear picture on the issue of family planning program in place. As a tool for evaluation of FP, identification of factors and responsible occasioning lack or inadequate contraceptive services can be useful in the implementation of strategies. The strategies improve the services for family planning and further promote the consumption of contraceptives among women.

In the last 10 years, there has been a significant reduction of unfulfilled need for family planning due to the rising provision of modern contraceptive contribution in most countries. This rate however, remains persistently high in some countries affecting more than a $1/5^{th}$ of women in marriage. In other nations, it is either increasing thus indicating that significant efforts are required to increase the awareness and address the concerns of unmet need (Bongaarts, 2014).

In a World Fertility Survey conducted in 1980, as documented in International Family planning perspectives to address the disparity demographic effect of the various methods on unmet family planning needs, where majority of the third World countries participated, like in Kenya, it was noted that contraceptive use is extremely low among the many Kenyan women would wish to have more children. However it varies with the category of women who do not want more children and or have the wish to get few children than the currently have, those who are not pregnant or infecund nor breastfeeding and are not protecting themselves against pregnancies during sexual intercourse although they have future plans for using the contraceptives.

There also those women who have well-financed medical programmes, are well educated and may want to use the modern methods of contraceptives but neither pregnant nor using any current method. Women who have achieved a primary education at the highest level were two times more likely to encounter a family planning unmet need (Assefa and Fikrewold, 2011). The same case applies to a place of residence and the partner's level of education. In such a case, the level of husband's education as compared to that of a

woman is insignificant and the information suggests that wife's level of education is relevant to the determination if unmet need were to be reduced (Ojakaa, 2008).

A study done by Assefa and Fikrewold (2011) found out that women in rural parts such as Western and Nyanza regions as well as in other parts were did not meet the need for family planning. These unmet needs include controlling, spacing, and the overall unmet need. Such kind of information does not necessarily indicate unavailability of family planning services but the lack of information concerning the same. Another thing is that the services offered and their quality do not encourage the access, or women are not involved in decision making which can be evidenced in urban regions (Wubegzier & Alemayehu 2011).

2.3.1 Factors influencing the family planning option

There are currently over one billion people between the ages of 15 and 24, by far the largest childbearing cohort in history (Bayer, 2002). Sexual activity among youth places them at risk of unintended pregnancy and STIs, including HIV/AIDS. Meeting the reproductive health needs of this underserved population is, therefore, an essential matter for global and domestic discussion since addressing the unmet contraceptive needs will dramatically effect on their health and future world population. This study, therefore, will provide a proper understanding of factors influencing the realization of contraceptive needs of this age group.

Individual contraceptive use is affected by factors at the personal, household, and community levels, but the geographic distribution of contraceptive utilization is often associated with contextual variables, particularly at the community level (Stephenson et al., 2007). These variables typically include economic, social, and cultural influences at the community level (Burgard, 2004). Increased use of contraception is linked to high growth rates (for population), soaring levels of unemployment, religious attachment, advanced socioeconomic position, and greater availability of contraceptive services (Grady, Klepinger, & Billy, 1993).

In the Philippines, a study indicated that provision of family planning and outreach services on the average women were significant predictors of the use of contraceptive services (DeGraff, 1997). Research in South Africa has also shown significant relationships between the wealth status, level of female autonomy, women's education level, and the choice of method of contraception (Stephenson *et al*., 2008). Other studies have explored the relationship between spatial patterns of modern contraceptive used and the influence of community-level factors. In Bangladesh and India, districts located on the border and which share a common language were positive outliers for contraceptive use (Amin *et al*., 2002).

In a comparison of 15 countries, Blanc *et al*. (2002) showed that within a year of starting a family planning method, 7-27 of women ceased to practice contraception for reasons related to the quality of the service environment. The provision of a range of contraceptive methods at family planning services has also been shown to influence

contraceptive option. In a U.S. study, rapid population growth, unemployment rates, religious inclination, ready access to family planning services privileged and socioeconomic position were all associated with increased uptake of contraceptives.

Similarly, a study in the Philippines found that the availability of family planning service and prevailing local labor-market environment and infrastructure development were strong influences on contraceptive use. Other studies have examined other community characteristics including the impact of levels of community economic development, levels of school participation, economic roles of children and community fertility norms on contraceptive (Chacko, 2001; Stephenson *et al*., 2002). Chacko (2001) indicates that the accessibility and quality of lasting government-provided health care at the village level affect the utilization of methods of contraception of present times. In a study in Guatemala, it was reported that after regulating social and demographic attributes, admission to services was found to be a significant correlate of contraceptive utility in the population (Bertrand *et al*., 2000).

2.3.2 Social barriers to modern contraceptive methods

According to Sedgh & Hussain (2014), many women and couples across sub-Saharan Africa do not practice modern contraception due to lack of adequate knowledge of the social, economic and health benefits of family planning. Some do not have an understanding of the appropriate method for them or do not know where to obtain a method. Others are discouraged from using any family planning method because they

believe that their family members, husband, or religion is against contraception (Elias, 2014).

Another critical obstacle to modern contraceptive utilization includes the stereotypes, and negative perceptions regarding the contemporary methods. These include erroneous or exaggerated accounts of the side effects, misconstruction about health outcomes in both long-term and short-term as well as harmful label about individuals utilizing the methods (Sedgh & Hussain, 2014). For example, researchers have found that in developing and developed worlds, women view pill utilization more harmful than pregnancy. Bradley, Fishel & Westoff (2012) reckon that about 70% of women attributed the use of methods such as the pill to elevated exposure to risks of morbidity.

According to a study conducted in Ghana by Elias (2014) found that many women feared that methods like the pill and the injection could cause permanent infertility. On the other hand, in Kenya it is estimated that sexually active women are aged 19–24 demonstrated as young adult female had misconceptions about the side effects of modern contraceptives, for instance, the belief that modern contraceptives cause infertility or can harm a woman's uterus. Besides, few but experienced or knew someone who had suffered an actual side effect such as weight gain (Bradley, Fishel & Westoff, 2012).

In a Kenyan study among reproductively active women, the information collected revealed that women using modern contraceptive could accumulate into a life-threatening medical such as nose and mouth bleeding and giving birth to children with deformities.

These negative perceptions are perpetuated among the peers and in social media, thereby popularizing them (Paz Soldan, 2004).

The prevalence of such myths and misconceptions has been evident in various national-level studies mostly in rural areas (Faye & Seck, 2013). In MLE baseline surveys carried between 2010 and 2011, more than half of the interviewed women in six cities in Senegal believed that users of contraceptive methods will have health issues including infertility. (Corroon & Okigbo, 2015). Similar results were found to replicate among men.

Studies in Kenya also reveal that men consider utilization of contraception methods as harmful to women. According to these studies, use of contraception is limited by low knowledge level. Where knowledge level is high, stereotypes and misconception inhibit use of modern ways of contraception (Campbell & Potts, 2006).

A study on contraceptive utilization found that between 26 of the 51 countries studied, an average of 20–50% of married women cited the side effects and health complications as major reasons for not using contraception. Similar findings were reported in sub-Saharan Africa (Corroon & Okigbo, 2015). Even in other parts of the world such as Mexico, misconceptions and myths are major driver for contraception nonuse. This is where women choose other methods or discontinue them altogether (Cleland *et al*., 2012).

As a driver for nonuse, myths differed substantially across Sub-Sahara where for instance in Kenya and Senegal, heath concerns were cited as barriers to contraception use. In married couples, contraceptive utilization is higher in Kenya than in Senegal (Corroon & Okigbo, 2015).

It is important to undertake research on the existing beliefs and perception on the various methods of contraception that are available. Identification of the barriers contributing t low contraceptive use is important for pertinent intervention. Such knowledge on the barriers would be critical in informing policy decision making. This way, policy on reproductive health and contraception would aim at addressing the barrier for enhanced contraceptive use (Cleland *et al*., 2012).

2.3.3 Economic factors influencing modern contraceptives methods

Economic factors may influence contraceptive in various ways. These factors are related to residential houses, employment status, level of education and others. Poor economic situation are responsible for the disruption of financial access (Ferdousi *et al*., 2010). Therefore, it encourages use of modern contraception to avoid burden, which comes with newborn babies. On the other hand, severe economic reasons such as poverty cause lack of access to contraceptives due to associated costs.

In addition, residential area of the young adult female is closely associated with economic factors influencing contraceptive use. Use of modern family planning contraceptives is much higher developed urban centres when compared to the women in informal

settlement in rural setups. This is because urban areas resident has infrastructural development such as hospitals, better education, and knowledge about modern contraceptives unlike in informal settlements (Ferdousi *et al*., 2010).

The multiple roles that women have contribute to low contraception utilization. According to Oluwasanmi *et al*. (2011), women who work outdoors are less likely to use contraception and family planning compared to those who remain indoors. One other study carried out in South Sudan showed that barriers of contraceptive utilization declined significantly, as the women reach higher education levels and employment status because these make them empowered as compared to women who have lower or no education and those without jobs or means of earning a livelihood (Abdel and Amira, 2013).

2.4 Theoretical framework

2.4.1 Theory of reasoned action

Icek Ajzen and Fishbein proposed Reasoned Action Theory as a way of improving Integration theory (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975). This model introduced two essential changes in the approach, and these include aspects of behavioral intention and persuasion. The theory is anchored on human beings because people have inherent capacity to think and use the information availed to them to make decisions. Individual engage in cost-benefit analysis and the outcome informs their course of action.

Reasoned Action theory does not attempt to predict the role of attitudes, but its emphasis is the behavior of individuals in a situation. In addition to this, this theory also recognizes other factors, which limit the behavior such as economic factors. The Theory of Planned Behavior was incorporated into this model to seal the inadequacies or fill the gaps (Ajzen, 2011).

According to the model, behavior is largely predicted by the social factors such as attitudes individuals' norms towards the behavior in question. This also happens through the intervention of economic factors such as cost and affordability. The necessary attitudes and subjective norms must be peculiar to a particular behavior in question. Further, the theory postulates that people think what others will perceive them about social expectation before considering their economic factors. These economic and social aspects exert a direct or indirect pressure to the individuals in question (Tsai, Chen & Chien, 2012).

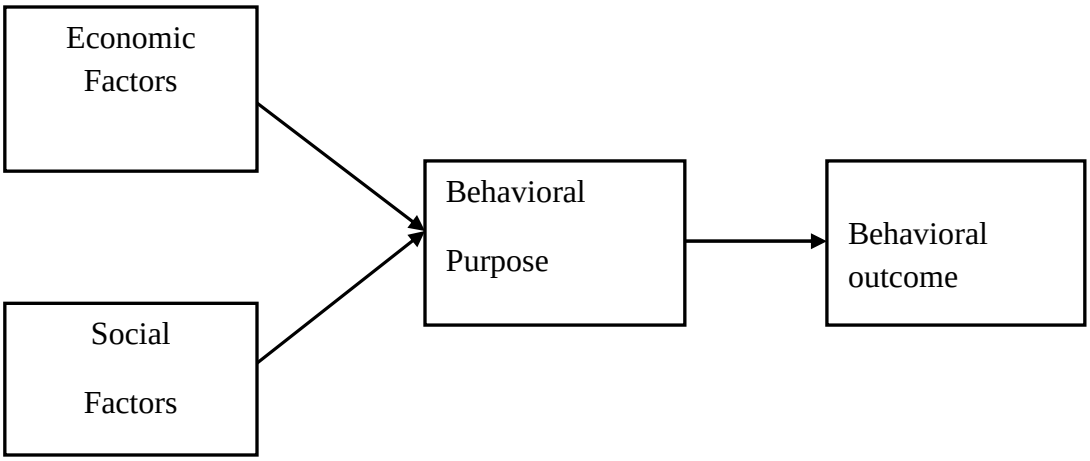

Figure 2.1: Diagram explaining the Theory of Reasoned Action (Fishbein & Ajzen, 1975).

2.4.2 Relevance of the theory to the study

This model will be used to explain how social and economic barriers affect modern family planning methods in informal settlements. According to the model, barriers to family planning among young adults in Mukuru kwa Njenga is seen when attitudes lead them to seek modern contraceptives, but economic factors suggest something else. The model is relevant because it responds to the objectives of the study that includes economic and social factors affecting the use of contemporary contraceptives amongst young women in Nairobi's informal settlements. For example, a woman would wish to adopt contemporary methods of contraception but the cost prevents her from accessing them. Therefore, both social and economic factors have influence the behavioral intent of the individuals. Therefore, the model predicts behavioral intention is a compromise between two factors and these includes social and economic factors. For the behaviors to happen both factors must into play, and the absence of one element will prohibit the actions from taking place or limit the intended behaviors by an individual.

2.5 Conceptual Framework

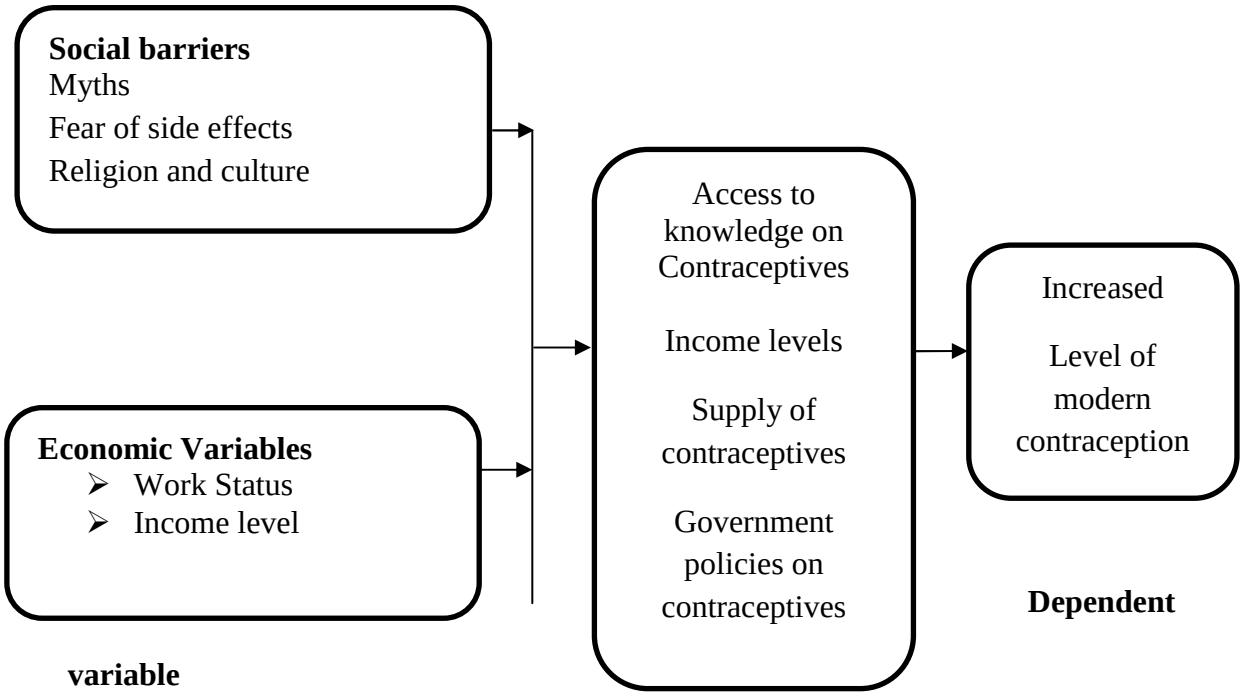

Figure 2.2: Conceptual Framework (Kaushik, 1999)

CHAPTER THREE: STUDY METHODOLOGY

3.1 Introduction

The methodology chapter details the study's location, the research design, target population, the unit of analysis, sampling and sample size, the methods used to collect data and analysis and finally the ethical considerations employed in this study.

3.2 Research site

The study was carried in Mukuru Kwa Njenga slum (Figure 3.2.1). This slum is situated in the East of Nairobi, the Kenya's capital. The slum spreads across Embakasi Constituency in Nairobi County. The settlement spreads over two sub locations, namely Imara Daima sub location to the West and Mukuru Kwa Njenga Sub location to the East (IEBC, 2011). According to 2009 national population census, the village has about 32,600 people and occupies 2.03 square kilometers (KNBS, 2009).

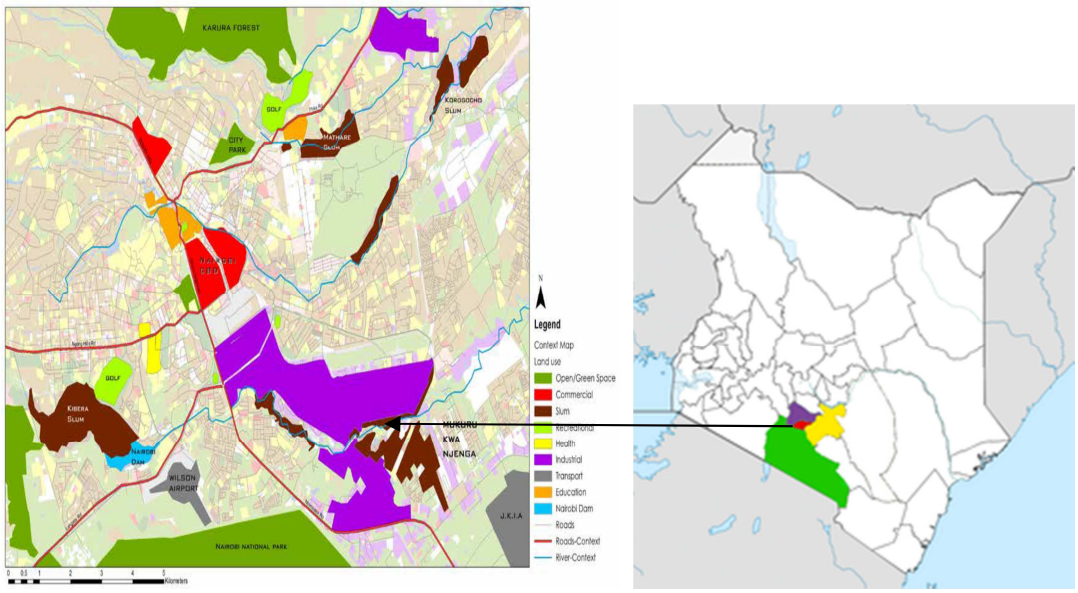

Figure 3.1: Map showing location of Mukuru in Nairobi County

3.3 Study Design

A cross-sectional research design and mixed method was used in this study. The design enabled the exploration of the factors influencing contraception use among young adults at one point on time. In addition, the mixed method helped in offsetting the weaknesses associated with each method and for triangulation.

3.4 Study Population and Unit of Analysis

This study was carried out among young female between the ages of 19-24 years in Mukuru kwa Njenga slum in Nairobi. Qualification for participating in the study included those who are not married but in a relationship, those matrimonial unions irrespective of their child status, those who are using family planning methods, those who used contraceptives but stopped. The unit of analysis was the individual young female. Besides, professionals in Nairobi County and those in the study area were also involved in data collection drive to enrich information from the survey questionnaires and other issues.

3.5 Sample size and Sampling Procedure

The study targeted 100 participants for survey (quantitative data). For qualitative data, the 10 case narratives and 5 key informants constituted the sample size. In the sampling procedure, convenience sampling technique was employed in choosing the sample population from the study population. This entailed solicitation for participation from potential participants, and if they met the criteria for inclusion and accepted to take part in the study were selected. This process was continued until all participants were

interviewed. The key informers were purposively chosen based on their knowledge about the study and selected through solicitation for participation or volunteering.

3.6 Data Collection Methods

3.6.1 Survey

Survey was used to collect qualitative data with the selected 100 respondents and collected information from young adults aged 19-24. The study used survey method to gather quantifiable data on the factors influencing modern family planning in Mukuru kwa Njenga slum. The information collected using the technique includes demographic, social, and economic barriers of modern contraceptive among young women aged 19-24. A questionnaire was used as a tool to collect the data.

3.6.3 Case narratives

Case narratives were used to qualitative collect data among selected young women from a population in Mukuru kwa Njenga slums. The method sought to understand subjectively the specific barriers to contemporary family planning and family planning, myths together with misconceptions about contraceptives and how they act as obstacles to family planning. The method helped understand the underlying meaning relating to use/access of contraceptives or family planning methods among the young female adults. A narrative guide was used to focus on the key themes regarding the factors influencing access and utilization of contraception or family planning services.

3.6.2 Key informant interviews

The study chose on 5 key informant for interviews. These were officials from the ministry of health, family planning providers, heads of health facilities in the area, and county health officers in the Nairobi regarding the prevailing status of family planning in informal settlements. The method sought information regarding the programs implemented by the government of Kenya, how they have helped address family planning needs and knowledge about contraceptives, challenges, and future strategies on issues of family planning among young women in informal settlements. A key informant interview guide was be used to focus on key thematic areas.

3.6 Data Analysis

Quantitative data was coded by use of SPSS software and analyzed and presented in figures and charts, followed by interpretation of the figures from the output tables or figures. Qualitative data from case narratives and key informant interviews was transcribed verbatim to English and important quotes that reflected the key themes extracted for use in this manuscript. After coding the data, content analysis was done to identify the key themes while checking the recurrences within and across the coded data.

3.7 Ethical Considerations

Prior to the study, permit to conduct research was sought from the National Commission for Science, Technology and Innovation (NACOSTI), Number NACOSTI/P/16/24314/1405. The researcher assured the respondents that the information was to be used strictly for the study and the source of the information also was to be

treated with confidentiality. In addition, the respondents were not required to give their names and contacts and any other information that can be used to identify them. Participation in the study was voluntary and the participants were informed that they were free to withdraw at any stage and that such withdrawal would not attract any disfavor whatsoever.

The researcher also disclosed the real purpose of the survey and the finding of the study was shared with the community and other researchers. Qualitative data from the study, key informant interview, and case narratives were recorded and translated in situations where Kiswahili has been used.

3.8 Problems faced and their Solutions

Reproductive health issues and contraception use is a sensitive topic in the society as it touches matters of sexuality. Thus, the researcher anticipated non-disclosure from the participants. However, to counter this, the researcher used a community leader and built rapport and with the participants and assured them of confidentiality and anonymity. Further, the questions were asked in less emotive ways. This facilitated disclosure of the rather sensitive issues

CHAPTER FOUR: BARRIERS FACED BY YOUNG WOMEN ADULTS IN ACCESSING MODERN CONTRACEPTIVE METHODS

4.1 Introduction

This chapter details the study outcome or findings as in the objectives and there are two sections. The first section reports the participants' demographic characteristics while the second one reports the outcome on the barriers faced by young adult females in accessing/utilizing modern contraceptive methods in Mukuru kwa Njenga slums, Nairobi City County. The study sought to investigate the barriers faced by young adult women in accessing modern contraceptive methods in Mukuru Kwa Njenga slums, Nairobi City County. The specific objectives were to establish social barriers and determine economic barriers faced by young adult females in accessing modern contraceptive methods in Mukuru Kwa Njenga slums, Nairobi City County.

4.1 Demographic characteristics of the Participants

4.1.1 Age

Although all the participants in the survey aged between 19 and 24 years, there was age differences that could be categorized into two major groups: 19-21 and 21-24. As shown in Table 4.1, majority of the respondents (60) aged between 22 and 24 and only 40 aged between 19 and 21.

Age Group	Frequency	Percentage
19-21	40	40%
22-24	60	60%

Table 4.1: Age of Respondents

The distribution of age among study respondents shows that they are in their early reproductive age, hence having a longer reproductive period and sexually active. This illustrates the need to focus on their access to modern contraceptive methods. One key informant that:

> *The importance of having comprehensive and accessible contraceptive services is that most of the consumers young people with longer reproductive age* (Key informant 3, Male, City County health provider)

The age of the respondents also meant that they are prone to influence from their peers in terms of the decision to use contraceptives. The young age may also indicate the time when they are exploring and discovering their sexuality and this would fundamentally influence their use of modern contraceptive methods.

4.1.2 Marital Status

While 35 respondents were married, majority of them (52) were single, and only 2 were separated. 11 respondents reported to be in relationship or engaged (Figure 4.1).

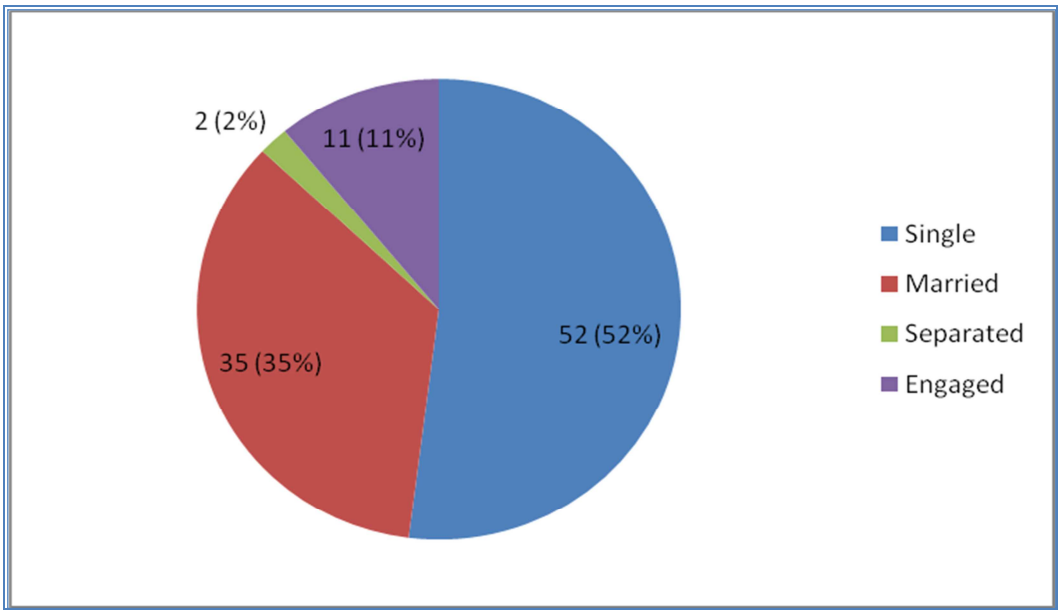

Figure 4.1: Respondents' marital status

The focus on marital status of the respondents was important because of the barriers associated with one's marital status in relation to the use of contraceptives. The findings showed that spouses can be source of barriers to contraceptive access and use specially when they discourage or disapprove the same. The quote below by a respondent indicates that marital status can influence utilization of contraceptive methods.

> *When you are married, it may become difficult to use some of the methods such as condom since the husband may be against it* (Respondent 2, 24 years old).

Further, being single or engaged in intimate relationship may influence the use of contraceptives in the same way it may influence married women (spouse decision). According to Hameed et al. (2014), spouses (husbands) may be a barrier to contraceptive

use and access when they do not support the idea. This indicates that marital status is an important variable in relation to being barriers to access and utilization of modern contraceptive methods.

4.1.3. Level of Education

Majority of the participants had secondary education (41) while only 10 had attained university level of education. While 9 had primary education, 40 participants had tertiary education. This is shown in the Figure 4.2

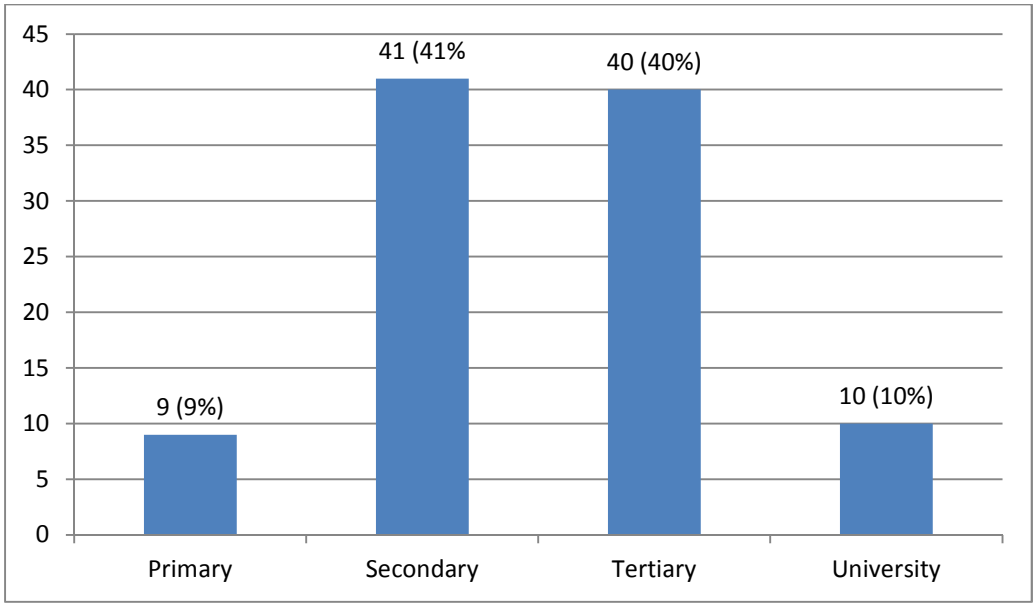

Figure 4.2: Respondents' education level

Measuring the education level was important in assessing the extent to which the level of education can be a barrier towards access and utilization of modern contraceptive methods by young adult women. The findings indicated that a correlation between

education level on one hand contraceptive utilization on the other hand and this is based on the knowledge level and the ability to demystify the myths surrounding contraceptives. The level of education may also be instrumental in overcoming other barriers such as religion as exemplified by the quotes.

> *Education plays an important role in terms of information and knowledge. You find that most young people who are well educated to college level have knowledge on the importance of contraceptives. However, education level may not be a guarantee because even the highly educated may not use them* (Key informant 5, Male, County reproductive health provider)

> *I know that with education, one can make good and informed decisions. Knowledge gap can be a big barrier to access and use of modern contraceptives. For example, if I do not know about implants, I may not use those* (Respondent 7, 20 Years old)

Quantitative data showed that 65% of those who accessed and used modern contraceptive methods had at least secondary education. Okech, Wawire and Mburu (2011) reckon that lack of awareness and knowledge on contraception may be a barrier towards utilization. Similarly, education level may influence other variables such as the financial capacity of the young adult women to afford contraceptives. This is because the education level may influence the economic status of individual n the society.

4.1.4. Occupation

The classification of the participants' level of education was done according to the kind of job that the participants reported. There were four categories: Informal employment, Business, full-time student, and Formal employment. Informal employment category included participants working in non-permanent sectors such as cleaning, part-time salon assistants, and other casual occupations whose payment is weekly or daily (wage). This category accounted for 30% of all the participants. Those who reported to be full-time students accounted for 29% (Figure 4.3). The business category included participants who reported to be self-employed and running businesses such as selling second-hand clothes, vending beverages and fruits, running informal hotels and kiosks. These accounted for 30%. The employed category include those participants who reported to work in the formal sector such as accountants and teachers and this accounted for only 11% of the participants as shown in Figure 4.2.

Measuring the respondents' occupation was important to assess the link between occupation (income) and access to modern contraceptive methods. The findings showed that low income is a barrier that limits access and utilization of contraceptive methods.

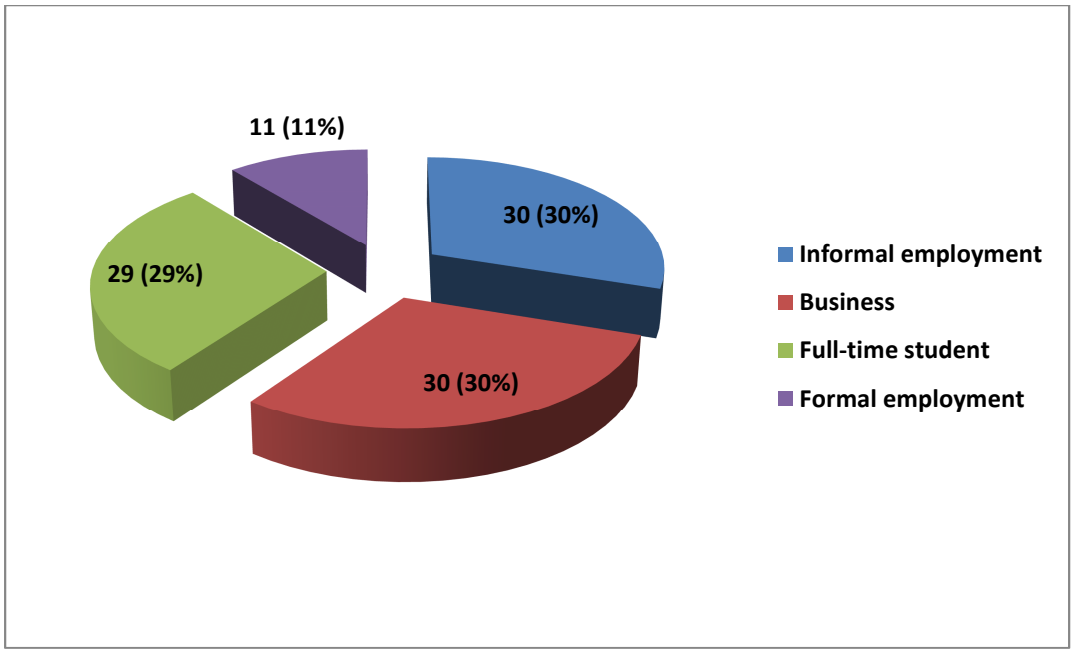

Figure 4.4: Respondents' occupation

Accordingly, 96% of respondents who reported to have formal employment also reported consistent access and use of contraceptives. Additionally, some of the respondents in informal employment reported lack of money to access contraceptives amid competing needs.

> *When there is no money, I do not use my usual injectable since they cost a lot. At times like that I fear because I can become pregnant anytime* (Respondent 5, 24 years)

The sentiments from a key informant also implicated low income as a barrier to contraceptives access and utilization.

> *Some clients do not turn up for subsequent visits and although this may be because of other factors, money remains the most defining*

one. This is especially the case if the woman relies on her husband and he is against the idea of contraception (Key informant 5, Male, County reproductive health provider)

Azmat *et al*. (2013) found out that in low-income settings, contraception use is equally low. This points to the view that individual occupation and the resultant income may become a barrier towards access and use of modern contraceptive methods.

4.1.5 Religion

Most participants (46) were Catholics, 32 were Protestants, while 15 belonged to other denominations. Only 7 of the participants were Muslims. This is shown in Table 4.2.

Religion	**Frequency**	**Percentage**
Catholic	46	46%
Protestant	32	32%
Muslim	7	7%
Other	15	15%

Table 4.2: Participants' religion

Religious beliefs on contraception may influence how young adult women use contraceptive methods. Thus, it was important to measure the religious affiliation of the respondent to assess whether religion as a social variable is a barrier to accessing and using contraceptives. Quantitative data showed that 70% of the Catholics cited

prohibition by religion to use contraceptives. This shows the extent to which religion can be a barrier in accessing contraceptives. A quote from case narratives puts this into perspective.

> *I am a catholic and my religion does not allow use of contraception. So I do not use any for now but I may use when need arise* (Respondent 9, 22 years).

According to Grady, Klepinger and Billy (1993), religious beliefs place barriers to family planning interventions since the beliefs run against best family planning practices such as modern contraceptive methods.

4.2 Contraception Access and Use among young adult women

The findings showed that the use of modern contraception methods is relatively low despite sexual activity by women. Figure 4.4 shows that few of the participants consistently use modern contraception. From the figure, only 40% of the participants reported consistent use of a given contraceptive method while 20% reported not to use at all and 22% use contraception intermittently.

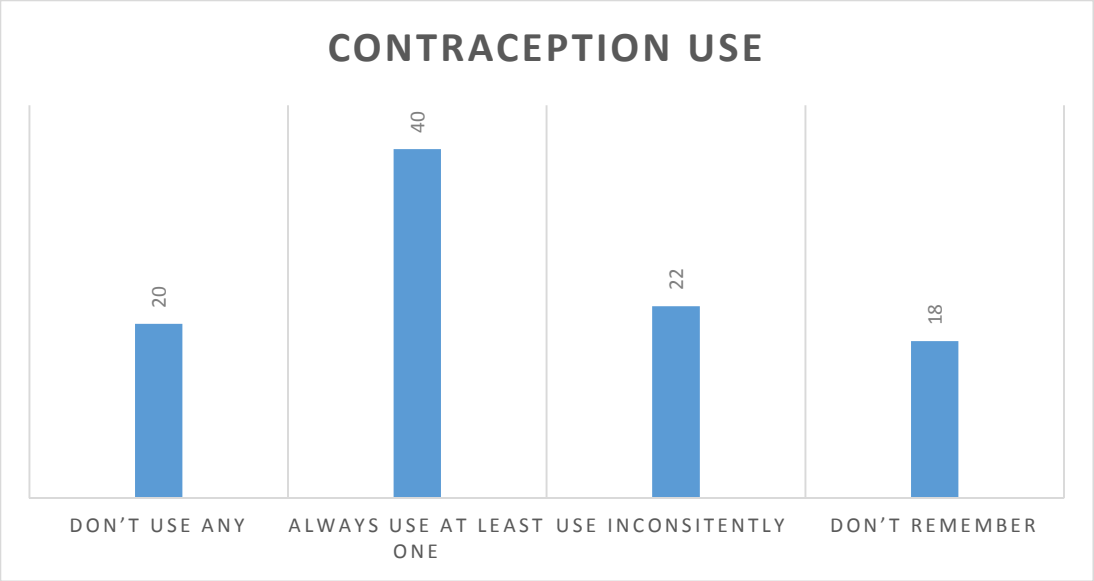

Figure 4.4: Contraception Use among the young adult women.

In addition, different methods of contraception are used for the first with differing frequency as shown in Figure 4.4, but participants may stop for different reasons. Apparently, among the methods at first use, condoms were cited as the commonest contraceptive method. However, some of the methods have fallen to disuse or low utilization, based on different factors discussed below.

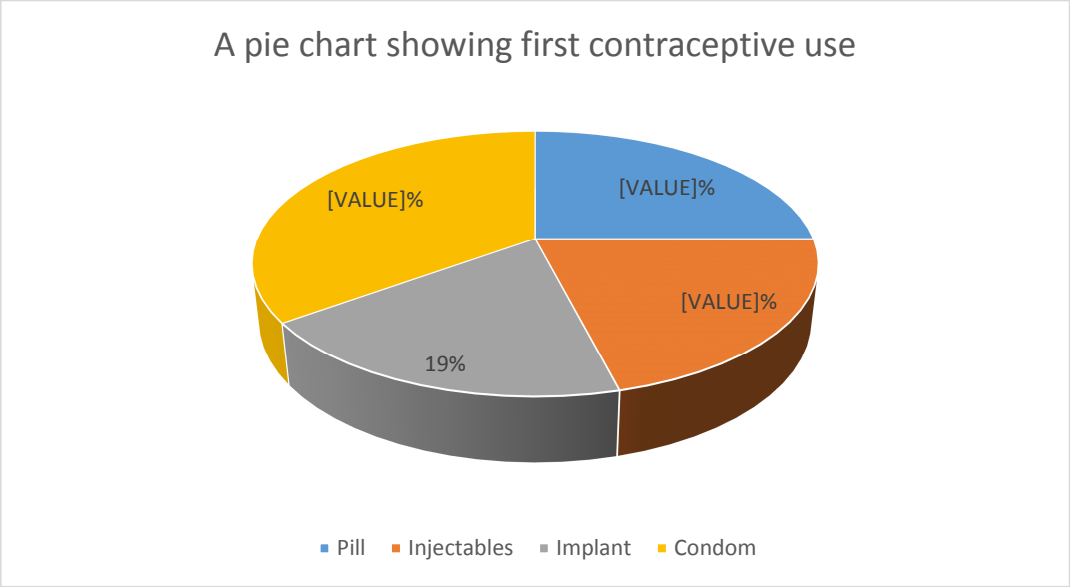

Figure 4.5: First contraceptive use

4.3 The social barriers towards access and utilization of modern contraception

The findings showed that social variables such as social perceptions and myths, gendered decision making, and religion, create fundamental barriers towards the access and utilization of modern contraception among the young adult women.

The myths and perceptions (misconceptions) regarding the use of modern contraception form a major barrier towards sustained utilization and access. Indeed, the findings showed that participants would abandon using or accessing a given method of contraception due to various reasons. Most participants cited fear of infertility as one of the reasons for not using contraception. Injectables and implant were cited as common causes of infertility, hence abandoning them. Other myths and perceptions contributing to low use of contraception include fear of the side effects, need for more children, and little risk of pregnancy. This is shown in Figure 4.6.

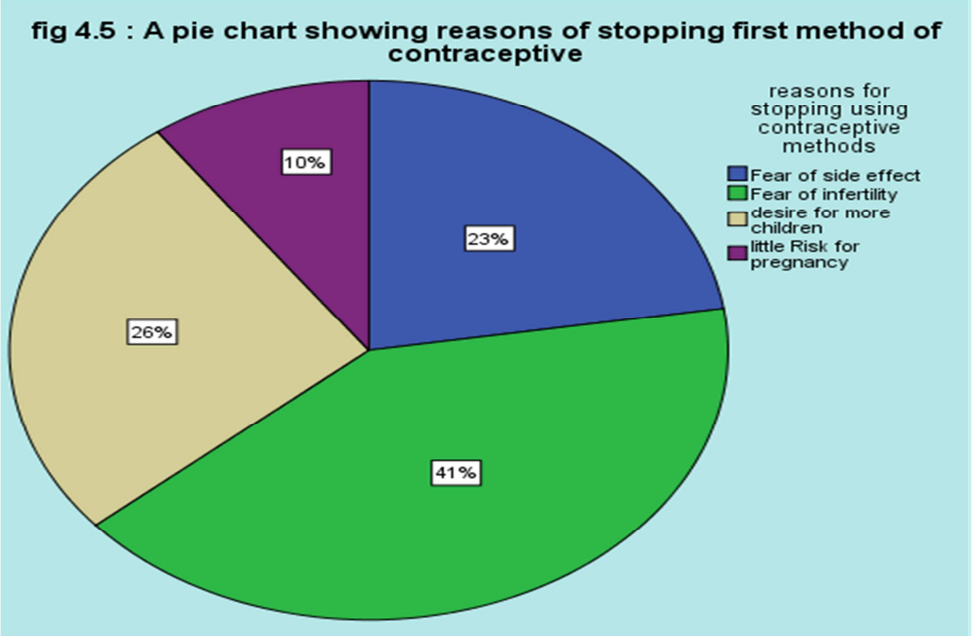

Figure 4.6: Why women would stop the first method of contraception

The case narratives supported the quantitative data on the myths and misconception of contraception that leads to low use. Consider the quotes below from young women adult in Mukuru kwa Njenga.

> *My friends say that when I use the implants, I may miss my periods and that it will take me a long time I get a baby* (Respondent 6, 20 years old).

> *There are some methods I cannot use because of the side effects. There is a day I used the pill and I experienced it [headache]. So I prefer condom or not use at all* (Respondent 2, 24 years old).

These sentiments on the myths and misconceptions are amplified by one key informant as exemplified in the quote below.

> *Majority of our clients ask us if they will ever get children when they use the implants because they are afraid. I think this is a negative perception that people have out there* (Key informant 3, Male, City County health provider)

Decision making power was also found to create a barrier towards poor access and low utilization of modern contraceptive methods. The idea is that power relations between men and women or husband and wife play a fundamental role in influencing women from accessing and utilizing modern contraception. Quantitative data showed that although most participants' partners discussed and approved a given method of contraception, gendered decision-making may at some points limit use and access of contraception. Figure 4.7 illustrates this.

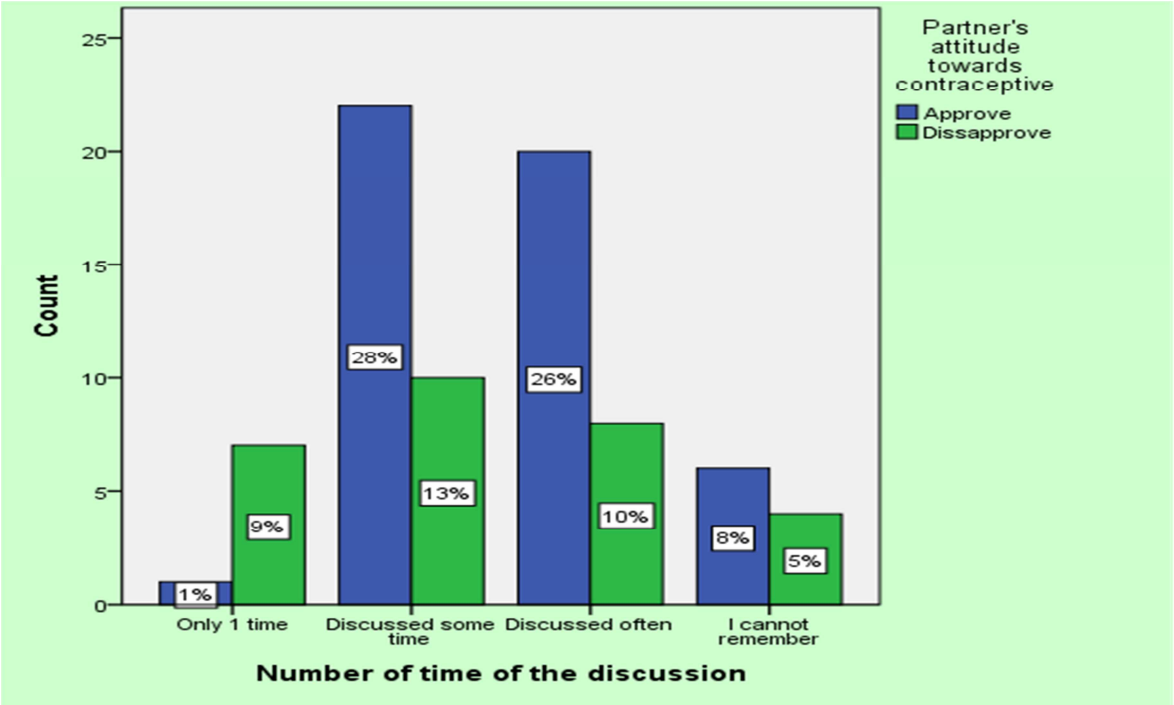

Figure 4.7: Contraception decision-making

The study sought to understand the partner's attitude toward the use of a particular method of contraceptive such as pills. Majority of the respondents according to the information collected had discussed about the use of contraceptive methods with their husbands or partners within the past one year. Out of those who had discussed it sometime, 28% of the partners had approved while 13% disapproved.

Those who had discussed it often, 26% of the partners had approved and 10% disapproved. Those who discussed the matter for only 1 time, 9% of the partners disapproved and only 1% approved from this category. From the figure above it is evident that majority discussed matters of contraceptive use with their partners but they

received different mixed reactions from their husbands as some approved and other disapproved the method in question.

The implication is that the partner's refusal to use contraception translates to low use of the methods by the young adults. The case narratives put this statement to perspective.

> *For me, I do what my partner demands because he may leave if I refuse. He said we cannot continue using condoms and we are married* (Respondent 10, 23 years old)

> *Although he [boyfriend] discusses the issue of contraception with me, he makes the decision over what we will use. We often use condom* (Respondent 4, 20 years old)

> *There is a day my husband told me we should not use pills as they will affect me. I decided to use without his knowledge because I did not want to become pregnant* (Respondent 8, 24 years)

The key informants reinforced this view by arguing that women may not make decisions on what contraception to use.

> *Men are domineering and instruct their women on what to do. Many women end here with abortion needs* (Key Informant 1, Female, Private reproductive healthcare provider)

> *Although some women remain tough, men decide sexual matters and may advise their women not to use certain methods or none at all* (Key informant 4, Female, County health provider)

Religion was also found to have a central role as a barrier towards access and utilization of contraception. Reinforcing the social myths and perceptions, religion was found to influence the way the women think about contraception and the consequences. The case narratives provided a subjective experience of contraception use in the face of religion.

> *Staunch Catholics follow the dogma and may not use for example condoms since the religion abhors that, although they also happen to have many children* (Key informant 5, Male, County reproductive health provider).

However, for other respondents, religion does not play a key role in contraception decision making

> *I cannot afford successive pregnancies because of the pastor says it is wrong to use contraception. So I defy religion* (Respondent 10, 23 years old)

> *Religious beliefs do not count in reproductive health. Let people use contraception at their own convenience without religious control* (Respondent 1, 23 years).

Nevertheless, the power of religion in creating barriers in access and utilization of modern contraceptive methods is evident and cannot be underestimated. Knowledge on contraceptive methods and how to use them well and consistently was also cited as a major issue in influencing utilization and access. Majority of respondents reported to only knowing one or none of the methods, thereby indicating a knowledge gap.

4.4 The Economic Barriers in Access and Utilization of Modern Contraception

The findings indicated that access and utilization of modern methods of contraception by young adult women is significantly influenced by the income or financial stability. The distance to travel to the healthcare providers for contraception services was cited as barrier as many participants cannot afford travel expenses often, especially in the face of competing needs.

	Minimum	Maximum	Mean	Std. Deviation
Minutes taken to travel for contraceptives	5	40	19.83	8.741

Table 4.3: Descriptive Statistics on Time taken

In addition, most participants were found to have occupations with no adequate income including joblessness and full-time studentship (Fig. 4.4), with average status income of kshs 6,000 – 9,000.

The case narratives also revealed the financial burden the women experience in accessing and utilizing modern contraceptive methods.

> *I prefer going for service [contraception] in town because here people will judge me. However, not all the time I have money even to buy the pills* (Respondent 4, 20 years)

> *When you have children, food and other needs to take care of, you lack the money to buy emergency pills or go for injection. You only hope that the husband will use a condom* (Respondent 5, 24 years).

> *Nowadays contraception is expensive and some of my friends may prefer going without* (Respondent 4, 20 years old)

The views of the key informants illustrate that financial constraints can be a barrier towards access and utilization of modern contraceptive methods.

> *Well, it is true that some methods are expensive and that is why many opt condom, which does not guarantee effectiveness* (Key informant 4, Female, County health provider)

> *I know of people whose cause of failure to use contraception is money. When women have to buy household items, they may forego contraception, especially when they have to rely on their husbands* (Key informant 3, Male, County health officer)

The findings thus show that poor access and use of modern ways of contraception amongst young adult women in Mukuru kwa Njenga slums is a function of social and economic factors. These mostly act as impediment towards access and utilization and they include myths and perceptions, gender relations in decision-making, religion, and financial constraints.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The chapter presents research objectives and findings summary. The objectives were to establish social barriers faced by young adult females in accessing modern contraceptives in Mukuru Kwa Njenga slums, Nairobi County and to determine economic barriers faced by among young adult females in accessing modern contraceptives Mukuru Kwa Njenga slums, Nairobi County. The study findings show that social and economic factors form the overarching barriers to access and utilization of modern contraceptive methods among young adult women.

5.2 Social barriers faced by young adult females in accessing modern contraceptives

Social factors are important in defining how healthcare services are accessed and utilized. These factors become more apparent in reproductive health and specifically in accessing and utilizing modern contraception methods. The study results shows that whereas women in the 19-24 age bracket are sexually active and in intimate relationships, the level of contraception utilization remains low. Barriers such as myths surrounding contraceptive methods, the fear of the side effects, religious beliefs or stand as well as knowledge gap create fundamental barrier in access and utilization of modern methods of contraception.

This may account for the high rates of pregnancy among this cohort. Further, it also accounts for rising levels of HIV infection among the group when condom use as contraception method declines. Similarly, Burgard (2004) observe that the consequences of low contraception use are exacerbated by social variables as well as cultural influences that do not support contraception. In regard to religious affiliation, Grady, Klepinger and Billy (1993) observe that religious beliefs influence contraception use when they prohibit use of contraceptive methods among the believers.

The issue of gender relations and power differences is a social factor that determines the use of contraception. Decision-making power vested on men and the fading women's decision making in a patriarchal society may not support contraception use if the power holders do not condone that. It becomes even more difficult if the religious standing does not support contraception use. The study findings indicate that poor access and utilization of contraception is aided by unwilling men partners who discourage or disapprove the use. Hameed et al. (2014) observe that lack of support from spouses may limit consistent use of contraception.

Further, the knowledge gap in relation to the understanding and awareness of the methods is a barrier towards access and utilization. According to Okech, Wawire and Mburu (2011), creation of awareness on the importance and use of contraception is an important step towards addressing the outcome of low contraception use.

5.3 Economic barriers faced by among young adult females in accessing modern contraceptives

Financial constraints have been identified as a powerful force undermining the access and utilization of modern contraceptive methods. The question of affordability of the methods and the sustainability emerge. This is where the low contraception use is manifested in low-income populations such as the one found in informal settlements. According Azmat *et al*. (2013) individuals and households in among the low-income populations have competing financial needs and contraception not only increases the financial burden but may be give up altogether. The study findings have indicated that some women would prefer attending to other household needs and forego contraception. This way, they may resort to other unreliable and traditional methods of contraception (Levin, Caldwell and Khuda, 1999).

Although some of the modern contraception methods are cheap, the embedded costs heighten their affordability (Hameed et al. 2014). As revealed in the study, some women prefer to visit far-distant centers in accessing the contraception methods. This introduces travel and other entrenched costs, thereby inflating the cost of contraception. Resultantly, some may not access and utilize the contraception services and methods and this manifests a major barrier.

5.4 Summary

The overall objective of the study was to explore barriers faced by young adult females in accessing modern contraceptive methods in Mukuru Kwa Njenga slums, Nairobi City County. The specific objectives were to establish social barriers faced by young adult females in accessing modern contraceptive methods and to determine economic barriers faced by young adult females in accessing modern contraceptive methods. The study respondents were aged between 19 and 24 years and lived in proximity where the contraceptive methods were easily accessible. The least travel time to access the contraceptives ranged between 5 and 40 minutes. The average time the respondents in this study had to travel to access the contraceptive methods was 20 minutes.

Many of the respondents had taken contraceptive methods at a very early age meaning that most of them could afford them but they has limited knowledge regarding the side effects and others issues such as infertility. In addition, many of the respondents had discussed about contraception with their husbands or partners within the past one year. Out of those who had discussed it sometime, 28% of the partners had approved while 13% disapproved.

Those who had discussed it often, 26% of the partners had approved and 10% disapproved. Those who discussed the matter for only 1 time, 9% of the partners disapproved and only 1% approved from this category. Upon using the contraceptives for the first time, 41% of the total respondents stopped using the contraceptive methods for fear of infertility. 26% stopped using the contraceptives since they had desire for more

children. 23% feared the contraceptive side effects while 10% of the total respondents considered the contraceptive methods to have little risk for pregnancy. On why the respondents were not to use the current contraceptive methods, it was clear that 51% of the total respondents gave a reason that they feared the side effects. 18% wanted to have more children, 16% believed there was a little pregnancy risk. The above findings can be interpreted that husbands or partners disapproval, culture, lack of proper awareness and perceived misconceptions hinder the young adult female to accessing the modern contraceptive methods.

5.5 Conclusion

Thus, the study concludes that the level of education, age, their monthly income, discussion with husband, boyfriend and husband and approval of spouse play a significant in the choice, use and stopping of contraceptive use. Other factors that act as a barrier to modern contraceptive incudes the fear of side effects and knowledge and therefore the economic aspect has been insignificant in determining contraceptive use. On the other hand, government intervention on matters of contraceptive use has been effective to some effect but there is need for more advocacy work to sensitive and increase their knowledge.

The government of Kenya has various policies in Kenya to deal with the cost, access, challenges, and opportunities relating to contraceptives use among people living in the informal settlements such as Mukuru kwa Njenga. This polices are in line with monitoring and progress towards achieving the goals of the global FP2020 initiative.

There are also programmes initiated by the government to sensitize young women on the use of modern contraceptives mostly focusing on shaping their attitude and boosting the knowledge relating to contraceptive use among young women and the general population. To eliminate the barriers, the government has put in place various measures such as ensuring the availability of modern contraceptives and providing subsidies when necessary.

5.6 Recommendations

The study makes some recommendations from the findings which can help increase use of modern contraceptives as well as improving their attitudes toward the same.

- There is need of educating young adults aged 19-24 at the point of service to help them make an informed choice on which contraceptive methods best fits them based on their needs. For instance, the choice to use family method planning is informed by either limiting or spacing of birth. Therefore, the need should be considered and advice accorded in line with it.
- There is a dire need for advocacy on matters relating to girl child education. From the findings, it is evident that the level of contraceptive use is largely dependent on the level education, the work status, and the level of income. Therefore, the government and other organization involved in programmes should accord more attention to this category of female group. In future, the government will require empowering women to through self-help groups to make them economically sustainable. This is in the light that income and contraceptive have a positive correlation.

- The study has also revealed the importance of men on matters of the method of modern contraceptive used. Therefore, government programmes should stress the need to share responsibility, include them in the sensitization campaign to improve their active participation and help them make informed decision when approving and disproving the choice of contraceptive use. They also need to have knowledge relating to reproductive behaviors and their reproductive rights and that of women in contraceptive use.

5.7 Areas of further research

The study suggests that other researchers should be replicated the topic of the study in informal settlements found in the rural setup found outside Nairobi. Emphasis should be put on the influence of economic factors and knowledge on contraceptive use.

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APPENDICES

Appendix I: Survey Questionnaire

Good Morning/Good Afternoon my name is Faith Osore, a Masters student at the University of Nairobi, Institute of Gender and Anthropology, carrying out research on barriers faced by young adult females in Mukuru kwa Njenga aged 19- 24 years in accessing modern contraceptive methods. You have been chosen to partake in this study by being a resident on this village which has been sample and by virtue of being in the reproductive age bracket defined in this study. My field of study will help identify and create awareness of the different factors affecting utilization of modern contraceptives services at the individual level. The results will be used by the various health initiatives and organizations to bridge the gap between the available family planning services and the population in need of them, through an implementation of the different measures of the factors affecting the utilization of modern family planning services.

I am going to ask you some questions that are not difficult to answer. Please feel free to respond to any questions you find comfortable. Your name will not be written in this form to preserve your anonymity and will never be used in connection with any of the information you tell me. You may choose to participate, not to participate, or withdraw from the study without any penalty or consequences. There will be no financial reward for participating in the study.

We would appreciate your help in responding to this survey questions .The interview will take about 30 minutes. Would you be willing to participate [indicate by ticking the appropriate responses]? Yes-------, No----------

Part I: Demographic and socioeconomic characteristics of the respondent				
Qn.	Questions	Choice of answer (Responses/Variables)	Code	Skip rule
1.	Age of respondent:	(1.) 19 years (2.) 20 years (3.) 21 years (4.) 22 years (5.) 23 years 6. 24 years		
2.	Marital status	(1.) Married (2.) Single (3.) Separated (4.) divorced 5. Widowed		
3.	Husband's occupation	(1.)Unskilled (2.) Mid-level (3.) Professional (4.) Others specify…….		
4.	Occupation	(1.) Student (2.) Business (3.) Informal employment (4) Formal employment		
5.	Monthly income. What is your monthly income	(1)Kshs. 0-2,999 (2)Kshs. 3,000-5,999 (3)Kshs. 6,000-9,999 (4)Kshs. 10,000 and above		
6.	Religion	(1.)Catholic (2.) Protestant (3.) (6.) Islam (7.) Others specify……		

8.	Educational status	1. Primary 2. Secondary 3. Tertiary 4. University		
9.	How many children do you have?	(1.) One Child …… (2.) Two Children…… (3.) Three Children….. (4.) Four Children and above…...		
Part II Sexual Reproductive Health History				
10.	At what age were you first married?			
11.	Have you ever been pregnant?	(1.) Yes (2.) No		If No go to Q 008
12.	How many pregnancies have you had?	…enter number		
13.	How old were you when you first got pregnant?	…enter age in year		
14.	After the child you are expecting now, would you like to have another child or would you prefer not to have any more children?	(1.) Have child (2.) No more (3.) Undecided (4) Don't know		
15.	If you preferred to have another child, how long would you like to wait before the birth of another child?	(1.) Yes (2.) No (3.) Not decided (4.) Do not know		Go to 028 Go to 030
16.	After the birth of the child you are expecting now, do you think that you will use any method to delay or avoid pregnancy at any time in the future? [For pregnant. Women]	(1.) Yes (2.) No (3.) Not decided (4.) Do not know		Go to 030
17.	Do you intend to use family planning in the future to delay or avoid pregnancy?	(1.) Yes (2.) No		

	[For post partum amenorrheic women]	(3.) Not decided (4.) Do not know		
18.	If the answer were yes, would you like to use method to space or limit pregnancy?	(1.) Yes (2.) No (3.) Not decided (4.) Do not know		
19.	Which method do you prefer to use?	(1.) Pill (2.) IUCD (3.) injectable (4.) implant [Norplant] (5.) condom (6.) Female sterilization (7.) Male sterilization (8.) Spermicidal [foaming tab. jelly] (9.) Natural method [periodic abstinence, withdrawal] (10.) Other specify…		
20.	If, you were not going to use any method to delay or avoid pregnancy at any time in the future would you tell me the main reason?	(1.) Not aware of contraception (2.) Fear of side effect (3.) Fear of infertility (4.) Unacceptable in my culture (5.) Medical problem (6.) Preferred method is not available (7.) Desire to have more children (8.) Husband or partner disapproval (9.) Religion prohibition (10.) Little perceived risk of pregnancy (11.) Other specify…		

21.	If you are not pregnant or amenorrhic would you like to have another child or not to have another child?	(1.) Have child (2.) No more child (3.) I cannot give birth (4.) Undecided (5.) Don't know		
22.	If you like to have a child how long would you like to wait from now before the birth of another child?	(1.)….enter month if less than 2 years (2.) 2 to 3 year (3.) 3 to 4 year (4.) More than 4 year (5.) Do not know		
Part III of Knowledge of contraceptive Methods				
23.	Please tell me to which group you belong regarding contraceptive practice?	1. Current user 2. Ever used 3. Non user 4. Other specify…		Go to 41
24.	If you have ever used contraceptive method, how old were you when you firststarted to use?	… enter age in year		
25.	How many living children did you have at that time?	…enter number of children		
26.	What was the method you used then?	(1.) Pill (2.) IUCD (3.) Injectables (4.) Implant [Norplant] (5.) Condom (6.) Female sterilization (7.) Male sterilization (8.) Spermicidal [foaming tabs, jelly] (9.) Natural method [periodic		

		abstinence, withdrawal] (10.) Other specify…		
27.	What was the main reason that you stopped using contraceptive method?	(1.) Fear of side effect (2.) Fear of infertility (3.) Medical problem (4.) Preferred method is not available (5.) Desire to have more children (6.) Little perceived risk of pregnancy (7.) Unacceptable in my culture (8.) Religion prohibition (9.) Other specify…		
28.	Do you intend to use any method to delay or avoid pregnancy at any time in the future?	(1.) Yes (2.) No (3.) Not decided (4.) Do not know		
29.	Tell me about rumors you hear concerning contraceptive methods?			
30.	Who talks about these rumors?	(1.) Current users (2.) Previous user/defaulters (3.) Non users (4.) Do not know (5.) Other specify….		
31.	If you are currently using the contraceptive method for what purpose?	(1.) Spacing birth (2.) Limiting birth (3.) Do not know (4.) Other specify…		
32.	What type of contraceptive method do you use currently?	(1.) Pill (2.) IUCD (3.) Injectables		

		(4.) Implant [Norplant] (5.) Condom (6.) Female sterilization (7.) Male sterilization (8.) Spermicidal [foaming tabs, jelly] (9.) Natural method [periodic abstinence, withdrawal] (10.) Other specify…		
33.	Would you say that using contraception is mainly your decision, or your husband or partner decision, or did you both decide Together?	1 Mainly respondent 2 Mainly husband or partner 3 Joint decision 4 No response		
34.	For how long have you been on this present contraceptive method without interruption?	…enter the period in Month		
35.	Are you practicing the same method currently?	1 Yes 2 No		
36.	Time taken to travel to the source of contraceptive methods?	…..write time in Minutes		
37.	If you were not using any contraceptive method to delay or avoid pregnancy, would you tell me the main reason?	1 Respondent opposed 2 Husband or partner opposed 3 Relative opposed 4 Knows no method 5 Knows no source 6 Health concern 7 Fear of side effect 8 Lack of access or too far		

		9 Little perceived risk of pregnancy 10 Too much cost 11 Inconvenient to use 12 Other specify… 13 to have more child		
38.	Do you intend to use any method to delay or avoid pregnancy at any time in the future?	1 Yes 2 No 3 Not decided 4 Do not know		
39.	If, yes which method would you prefer to use?	(1.) Pill (2.) IUCD (3.) Injectables (4.) Implant [Norplant] (5.) Condom (6.) Female sterilization (7.) Male sterilization (8.) Spermicidal [foaming tabs, jelly] (9.) Natural method [periodic abstinence, withdrawal] (10.) Other specify…		
40.	You will use the contraceptive method for what purpose?	(1.) Spacing (2.) Limiting birth [no more child] (3.) Do not know		
41.	After how long you want to use contraceptive method?	(1.) Write in month if less than 2 year (2.) 2 to 3 year (3.) 3 to 4 year (4.) More than four year (5.) Do not know		

42.	If you were not going to use a family planning method to delay or avoid pregnancy in the future would you tell me the main reason?	(1.) Respondent opposed (2.) Husband or partner opposed (3.) Relative oppose (4.) Desire for more children (5.) Religion prohibition (6.) Culture prohibition (7.) Knows no method (8.) knows no source (9.) Health concern (10.) Fear of side effect (11.) Lack of access or too far (12.) Little perceived risk of pregnancy (13.) Other specify…		
43.	Have you have discussed about use of contraception with your husband or partner within the last one-year?	(1.) Yes (2.) No (3.) Do not know		
44.	If the answer were yes, how many times have you discussed?	(1) Only 1 time (2) Discussed some time (3) Discussed often (4) I cannot remember		
45.	What is your husband or partner attitude towards Contraceptive methods?	(1) Approve (2) Disapprove (3) Do not know		
Any other comments or inputs				

Signature of the interviewer certifying that the informed consent has been verbally by respondents----------

Thank You Very Much for You Participation

Interviewer's name: ……..

Result (1) completed, Result (2) respondents not available, Result (3) Respondent refused

001 –Interviewer code ----------/----------/Name----------

002 –Name of the Village in Mukuru kwa Njenga of the respondent----------

Nearest facility:…..

003 – Date of interview:---------/---------/------Start time: …… End Time: …….

004 – Checked by supervisor. (1) Yes (2.) No

Signature---------- day----------month----------year.

Note: This questionnaire will be administered to women between the ages of 18-49 years. Family Planning Method Users or Defaulters, Never Users are asked. You Should Circle among the multiple choices the right answers or write the code.

Appendix II: Key Informant Interview Guide

Good Morning/Good Afternoon my name is Faith Osore, a Masters student at the University of Nairobi, Institute of Gender and Anthropology, carrying out research on barriers faced by young adult female in Mukuru kwa Njenga aged 19- 24 years, in accessing modern contraceptive methods. You have been chosen to partake in this study by being a resident on this village which has been sample and by virtue of being in the reproductive age bracket defined in this study. My field of study will help identify and create awareness of the different factors affecting utilization of modern contraceptives services at the individual level. The results will be used by the various health initiatives and organizations to bridge the gap between the available family planning services and the population in need of them, through an implementation of the different measures of the factors affecting the utilization of modern family planning services.

I am going to ask you some questions that are not difficult to answer. Please feel free to respond to any questions you find comfortable. Your name will not be written in this form to preserve your anonymity and will never be used in connection with any of the information you tell me. You may choose to participate, not to participate, or withdraw from the study without any penalty or consequences. There will be no financial reward for participating in the study.

We would appreciate your help in responding to this survey questions .The interview will take about 30 minutes. Would you be willing to participate [indicate by ticking the appropriate responses]? Yes-------, No----------

Signature of the interviewer certifying that the informed consent has been verbally by respondents----------

Interviewer's name: ……..

Result (1) completed, Result (2) respondents not available, Result (3) Respondent refused

001 –Interviewer code ----------/----------/Name----------

002 –Name of the Village in Mukuru Kwa Njenga of the respondent----------

Nearest facility:…..

003 – Date of interview:---------/---------/------Start time: …… End Time: …….

004 – Checked by supervisor. (1) Yes (2.) No

Signature---------- day----------month----------year.

1. What is the level of family planning services to the slum community?
2. What is the level of modern family method knowledge among these young adult female in Mukuru Kwa Njenga slums?
3. What are some of the barriers women in the slum face in accessing and utilizing modern family planning methods in the slums?
4. How has the government tried to eliminate social and economic bariers to modern family planning in informal settlements?
5. Do you know if there are facilities that provide modern contraceptives at subsidized costs in informal settlements?

Thank you for your cooperation.

Appendix III: Case Narrative Interview Guide

Good Morning/Good Afternoon my name is Faith Osore, a Masters student at the University of Nairobi, Institute of Gender and Anthropology carrying out research on barriers faced by young adult female in Mukuru kwa Njenga aged 19- 24 years in accessing modern contraceptive methods. You have been chosen to partake in this study by being a resident on this village which has been sample and by virtue of being in the reproductive age bracket defined in this study. My field of study will help identify and create awareness of the different factors affecting utilization of modern contraceptives services at the individual level. The results will be used by the various health initiatives and organizations to bridge the gap between the available family planning services and the population in need of them, through an implementation of the different measures of the factors affecting the utilization of modern family planning services.

I am going to ask you some questions that are not difficult to answer. Please feel free to respond to any questions you find comfortable. You may choose to participate, not to participate, or withdraw from the study without any penalty or consequences. There will be no financial reward for participating in the study.

We would appreciate your help in responding to this survey questions .The interview will take about 30 minutes. Would you be willing to participate [indicate by ticking the appropriate responses]? Yes-------, No----------

Signature of the interviewer certifying that the informed consent has been verbally by respondents----------

Thank you for your cooperation.

Interviewer's name: ……..

Result (1) completed, Result (2) respondents not available, Result (3) Respondent refused

001 –Interviewer code ----------/----------/Name----------

002 –Name of the Village in Mukuru Kwa Njenga of the respondent----------

Nearest facility: ……..

003 – Date of interview: ---------/---------/------Start time: …… End Time: …….

004 – Checked by supervisor. (1) Yes (2.) No

Signature---------- day----------month----------year.

Please tell me about your experience about family planning. Thank you.

Thank you for your cooperation.